

Inventing the Future of Healthcare

TOP CEOs ON THE REAL WORK OF
TRANSFORMING THE HEALTHCARE INDUSTRY

Insights from the **Huron Healthcare CEO Forum**

HuronHealthcare

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LETTER FROM HURON CONSULTING GROUP CEO JAMES H. ROTH

Rapid change is the new normal in the healthcare industry. The challenges of today's marketplace call for new approaches to care delivery, cost structures, and performance improvement. At this year's Huron Healthcare CEO Forum, healthcare CEOs gathered to discuss these challenges and how they are meeting them.

It is always a privilege to hear industry leaders describe their strategic views for moving their organizations forward. This year, more than ever, innovation is key. At Huron, we are pleased to provide highlights of these discussions. We believe the insights from this year's Forum will be relevant not only to other healthcare leaders, but to all CEOs whose industries are undergoing rapid change.

For those who attended, I offer my thanks. I trust this report will be a valuable guide for many executives as they navigate the changes that lie ahead.



James H. Roth

Chief Executive Officer and President
Huron Consulting Group



EXECUTIVE SUMMARY

Timing is everything. This concept ran through the third annual Huron Healthcare CEO Forum, as more than 30 healthcare CEOs discussed their visions for the future. The need to move from a business model based on volume to a new model based on value was widely recognized. But what's the right pace? How can this change be structured to ensure high quality, affordable care without compromising revenue streams?

Clearly, there's no one right answer. New payment models are taking hold at different speeds in different markets, and the complexity of the change means the transition is uneven. Yet, in various ways, all CEOs are preparing for a value-based payment model and a significantly reduced cost structure.

Some organizations are meeting today's challenges by forging fundamentally different relationships with payers or using advanced analytics to manage individual and population health. Others are pursuing new care models. All are building the competencies needed to thrive.

In any changing environment, there can be penalties for moving too slowly—or too fast. One CEO, for example, told of placing case managers in his organization's emergency departments. The change brought more coordinated care and improved patient satisfaction. But the initiative proved too costly to sustain, since there was no reimbursement for the enhanced value. "We were doing the right thing," the CEO said. "We just couldn't afford to keep doing it."

In addition to getting the timing right, CEOs also addressed other top challenges at this year's Forum, including:

- **Aligning Stakeholders:** CEOs agreed that aligning stakeholders—especially physicians—around a value-based mission is crucial, and they shared strategies for leading this change.
- **Exploring New Business Models:** ACOs, population health management, and other arrangements for sharing savings and risk are getting a lot of attention. CEOs are pulling together the key

competencies needed to make these new models succeed.

- **Leveraging Size and Scale:** CEOs are exploring ways to work more effectively by leveraging size and scale—including acquisitions, strategic partnerships, and collaboration.
- **Using Powerful Analytics:** Advanced analytics—especially clinical analytics—are crucial to evidence-based decisions. The right analytics can help organizations provide efficient, effective clinical care, make accurate risk assumptions, and predict resource needs.
- **Establishing New Primary Care Models:** Many CEOs see new primary care models as a cornerstone of the new healthcare environment. Strengthening the role of primary care teams is one key to success.
- **Evaluating New Care Settings:** CEOs are testing new approaches—such as Patient Centered Medical Homes, telemedicine, virtual care monitoring, and robust post-acute services—to lower costs, improve care, and increase patient satisfaction.
- **Forging New Relationships With Payers:** CEOs are increasingly receptive to innovative partnerships with payers. These partnerships include shared risk programs with insurers as well as new models of contracting with large employers.
- **Implementing Next Generation Performance Improvement:** As business models evolve, CEOs are focusing more than ever on performance improvement. Many are pursuing new levels of performance in core areas such as revenue cycle, supply chain, labor, and clinical operations.

As in years past, Forum participants were excited and optimistic to be at the forefront of change. The challenges are significant—but as they meet them, they know their organizations are advancing their missions by offering more affordable, high quality care, while helping to create a stronger future for healthcare.

EXECUTIVES FEATURED IN REPORT



NANCY HOWELL AGEE
President & CEO,
Carilion Clinic



STEVE CARLSON
President & CEO,
Community Medical Center



**WILLIAM K. ATKINSON,
PHD, MPH, MPA**
President & CEO,
WakeMed Health & Hospitals



PATRICK A. CHARMEL
President & CEO,
Griffin Health Services Corporation



TERRY A. BELMONT
UC Irvine Medical Center, CEO,
Associate Vice Chancellor for
Medical Center Affairs



CHRIS D. CONSTANTINO
Executive Director,
Elmhurst Hospital Center



DAVID L. BERND
CEO,
Sentara Healthcare,
CEO Forum Co-Chair



MICHAEL J. DOWLING
President & CEO,
North Shore-LIJ Health System,
CEO Forum Chair



MARNA P. BORGSTROM
President & CEO,
Yale-New Haven Hospital,
Yale New Haven Health System



DAVID T. FEINBERG, MD, MBA
CEO & Associate Vice Chancellor,
UCLA Hospital System and
Health Sciences



WILLIAM BROWN, FACHE
CEO,
Westlake Hospital



JAMES G. GALLAS
Managing Director,
Huron Healthcare

CEO ATTENDEES



DEAN M. HARRISON
President & CEO,
Northwestern Memorial HealthCare



JEFF JONES
Managing Director,
Huron Healthcare



M. MICHELLE HOOD
President & CEO,
Eastern Maine Healthcare Systems



ELLIOT JOSEPH
President & CEO,
Hartford HealthCare



L. LEE ISLEY, PHD, FACHE
CEO,
Granville Health System



**GARY S. KAPLAN, MD, FACP,
FACMPE, FACPE**
Chairman & CEO,
Virginia Mason Health System



**CATHERINE A. JACOBSON,
FHFMA, CPA**
President & CEO,
Froedtert Health



MARK LANEY, MD
President & CEO,
Heartland Health



REYNOLD JENNINGS
President & CEO,
WellStar Health System



GORDON J. MOUNTFORD
Executive Vice President,
Huron Healthcare



LOWELL W. JOHNSON, FACHE
CEO,
Salinas Valley Memorial
Healthcare System



JOSEPH J. MULLANY
President,
Detroit Medical Center

The CEO Forum included attendees from 11 hospitals and 20 healthcare systems from throughout the United States, representing over 200,000 employees, more than 30,000 licensed beds and a combined net patient revenue of \$37.5 billion.

These CEO leaders are consistently recognized by the industry for their many outstanding achievements. CEO Forum attendees represented 55 hospitals that are among the Best Regional Hospitals as ranked by *U.S. News & World Report*.

Seventeen attendees were featured in *Becker's Hospital Review's* "300 Hospital and Health System Leaders to Know" list, and five appeared on *Modern Healthcare's* latest "Top 100 Most Influential People in Healthcare" list.

EXECUTIVES FEATURED IN REPORT



KEVIN SCHOEPLIN
CEO,
OSF Healthcare System



KATE WALSH
President & CEO,
Boston Medical Center



JAMES H. SKOGSBERGH
President & CEO,
Advocate Health Care



CURT B. WHELAN
Managing Director,
Huron Healthcare



AL STUBBLEFIELD
President, Baptist Leadership Group,
President Emeritus, Baptist Health Care



DAN WOLTERMAN
President & CEO,
Memorial Hermann
Healthcare System



MICHAEL VIVODA
President & CEO,
Cadence Health



ANDREW A. ZISKIND, MD
Managing Director,
Huron Healthcare

Key Challenges & Opportunities

PRIORITIES, PEOPLE, PATIENTS
AND PURPOSE

Leading Through Disruptive Innovation to Make Organizational Change Real

Transformative change is needed to move the healthcare enterprise from where it is today to where it will need to be in the future. CEOs are playing critical roles by setting priorities and asserting strong leadership.

1) Transitioning Organizational Focus and Capabilities to Move from Volume to Value

CEO discussions at the Forum focused on when and how the transition to value-based care delivery will happen—not if. The shift will require significant changes in culture, capabilities, and business structures. Executives have a clear sense of the work

they will need to do, but turning the ship at the right time, at the right pace, and in the right direction remains a major challenge:

DAVID L. BERND: The timing between the old vision and the new vision for healthcare—the first curve and second curve—is really hard. Straddling the fee-for-service payment methodology is almost impossible from a financial standpoint.

MICHAEL J. DOWLING: There are still some hospital executives who believe fee-for-service will last forever. They think they can stay open by just working with the remnants of that kind of reimbursement. The market is

shifting away from fee-for-service payments toward value-based purchasing. We are working to make sure we stay on the edge of those changes and will keep fee-for-service approaches while we build the value-based model capabilities for the future.

MARNA P. BORGSTROM: Few leaders really understand just how challenging the cultural shifts will be during the transformation of our current healthcare system.

WILLIAM K. ATKINSON: Even if tomorrow we run off to work on well care instead of sick care, payment reform will still be against us. No matter what we want to do or try to do, we're going to be in the sick business, not the well business, for some time to come.

JAMES H. SKOGSBERGH: We definitely have a foot in two worlds. And on any day it's problematic. When we look at our utilization numbers, for instance, we feel schizophrenic. This number is good—no it's bad!—no it's good!

L. LEE ISLEY: We're a small organization. So we're either going to fail really fast, or it's going to work. If we aren't going to fix it, who is?

REYNOLD JENNINGS: Most of what we've always done—and much of what we will do—is episodic and transactional. That's got to change for chronic illness, and it's not going to be easy.

DAN WOLTERMAN: Everyone must work on changing their culture as we move from fee-for-service to value-based payment models. It's like moving from our success on the first curve to where we land on the second curve. The key question is, how do you retain focus on core competencies for success while stimulating progress?

AL STUBBLEFIELD: This industry has not made the transition to wellness healthcare. We're still looking for sick people. That's still how we make our money. Hospitals and health systems investing in public health initiatives are still going to be few and far between. Do you carve out a niche to deal with wellness care?

As the payment model mix continues to shift at different speeds in different markets, it presents a significant operational and leadership challenge for CEOs. Healthcare leaders are developing many innovative strategies for operating under two models simultaneously, while positioning their organizations for the future, in which value-based models will continue to expand.”

GORDON J. MOUNTFORD
Executive Vice President
Huron Healthcare

Leading Through Disruptive Innovation to Make Organizational Change Real

Executives also shared their perspectives on the challenges of building value-based care delivery capabilities:

JAMES H. SKOGSBERGH: It takes more time to build new infrastructures than any of us think. Whatever amount of time you thought it was going to take, double it.

REYNOLD JENNINGS: Three percent of chronic patients create a majority of the costs in healthcare. In the new world order to address that three percent, you've got to address medication management issues, social issues, and preventive care to avoid patients crashing into your ER and ICUs. The question is, can I do that with all of my physicians? Or should I bifurcate—give complex or tough patients to a smaller group of physicians? Will that help me keep my costs down for high-risk groups?

DAVID L. BERND: Fee-for-service is a train wreck, preventing us from doing what's right for patients. Payment methodology is the basic problem in this industry. We need to move on.

DEAN M. HARRISON: Recently we eliminated our case manager role because of its redundancy with other roles such as clinical documentation specialists, RNs, and social workers. We now have our bedside RNs place greater focus on advancing the plan of care and we added social workers to enhance care transitions. We also found that many of our readmissions could be traced to the lack of a primary care physician, so we added a primary care follow-up clinic, which has proven effective.

WILLIAM BROWN: We live in the last bastion of fee-for-service medicine. We are putting a lot of emphasis right now on clinical integration and moving toward a fee-for-value system, which will help us to improve length of stay, lower costs, and improve quality of care, making us a high-reliability organization.

CATHERINE A. JACOBSON: We're experimenting with different models of managing healthcare at our community-based facilities. One thing we're trying is to give one group of physicians more complex patients, to help better manage care for those patients who tend to consume more resources. We'll have to see whether it works.

MICHAEL J. DOWLING: As our revenues have shifted dramatically toward outpatient activities, we are re-thinking the roles of a few of our traditional hospitals. Opening ambulatory care centers is a major activity for us right now. We've also created a population health management division. Population health requires such a different management focus than fee-for-service medicine, so we decided separate management structures were best for now.

ELLIOT JOSEPH: I am focused on our senior management team. We are working hard to prepare our organization culturally for change. We are putting in a clinical integration infrastructure and hiring a new physician CEO for our Clinical Integration Organization.

M. MICHELLE HOOD: We just looked at what we need in executive competencies. We need people who can deal with ambiguity; we need people who can put together interdisciplinary teams and lead them by finding common threads.

DAN WOLTERMAN: We are now in the process of changing our culture. Our vision is very simple—to advance health. To manage population health, all parts of our organization have to be integrated and incented and be aligned and work together. Instead of the hospitals being their own little silos and getting incentivized and accounted for on their own, we're now going to just one accounting statement. We're trying to change the culture. We want employees focused on safe and efficient patient care.

L. LEE ISLEY: Patient navigators and care coordinators are now embedded into our organization. Regardless of whether we get better at providing wellness care, people are still going to get sick and need to be cared for in a hospital setting. But they don't need to spend 17 days in my ICU if they only need to be there for four. We need a less costly healthcare structure.

STEVE CARLSON: We're structuring for wellness. We have case managers embedded in our clinics, and we've partnered with the YMCA to address childhood obesity issues. We're helping coordinate access and transport to the YMCA to make sure children stay active.

CURT B. WHELAN: Healthcare leaders are working to identify cost reduction strategies that make sense both now and under future payment models. One of the biggest challenges is how aggressively to manage care while we are still largely functioning in a fee-for-service system. Timing the change is very challenging.

GORDON J. MOUNTFORD: As the payment model mix continues to shift at different speeds in different markets, it presents a significant operational and leadership challenge for CEOs. Healthcare leaders are developing many innovative strategies for operating under two models simultaneously, while positioning their organizations for the future, in which value-based models will continue to expand.

JEFF JONES: CEOs are turning the ship toward value-based models. As utilization and readmission rates go down, and wellness programs keep people out of hospitals, organizations are starting to lose money in certain areas. The next set of challenges will be around questions like: How do you put the right metrics in place to evaluate your progress? How do you create a learning organization that can course correct before losing too much money? How do you determine what's working and what's not? How much money do you need to cover your learning curve?

2) Lowering Costs While Improving Quality

CEOs agreed that the new landscape will require delivering higher quality healthcare within a lower cost structure, underpinned by enabling IT infrastructure. This imperative is being driven by the unsustainable trajectory of healthcare spending in the U.S., lower commercial and federal reimbursement, regulatory changes, and employer and consumer demand.

All CEOs had set cost-reduction targets, generally aiming to take 20 to 40 percent of costs out of their organizations. Significantly reducing costs will allow them to make the capital investments needed to shift to value-based approaches, achieve breakthrough quality improvements, and maintain margins at Medicare rates:

REYNOLD JENNINGS: To compete in today's market, you can't just be at break even overall.

LOWELL W. JOHNSON: We'd better be ready to live on Medicare rates.

ANDREW A. ZISKIND: Every hospital, health system, and large group physician executive is thinking about their basic cost structure. They're paying attention to the performance improvement efforts around operational efficiency and clinical efficiency, leveraging the benefits of consolidation, and functioning as a system. CEOs are also moving on asset rationalization—making sure they've got the right number of the right resources in the right place at the right time.

Where do cost reduction opportunities come from? The general answer was “everywhere.” Discussions at the Forum explored the following areas:

NEW BUSINESS RELATIONSHIPS WITH PHYSICIANS

Physicians are crucial to the success of any value-based endeavor. CEOs discussed some of the key components of successful business

relationships with physicians, noting that there is increased competition between providers for recruiting and employing doctors. In some markets, that competition is intense:

CATHERINE A. JACOBSON: In our market [Milwaukee], one large system started buying up doctor practices everywhere. We all followed suit, and within a short five-year timeframe, virtually every doctor had a primary affiliation with a single health

system. There no longer are any split-admitters. I am told that Chicago is going through a similar pattern.

MICHAEL J. DOWLING: To really prepare for value-based payment models, I believe physician relationships have to be the highest priority. We have been aggressively building a very large medical group, now numbering around 2,500 doctors. This is three times the size it was just three years ago. We are also, of course, building closer relationships with the thousands of physicians who will still be key members of our network.

JAMES H. SKOGSBERGH: We employ primary care and specialist physicians in a 50/50 split. Our growth will be in primary care. Some markets are less balanced. We do have doctors knocking on our door. It's a hard decision to have to make when you're not looking to buy.

However, not every organization has been as aggressive in recruiting:

REYNOLD JENNINGS: We do not want to employ all of the doctors in our market. We think the magic number is around 65 percent.

NANCY HOWELL AGEE: Will there be enough physicians in 10 years? Will there be a shortage? It's hard to say. Care delivery is changing, and there will be increased diversity among which clinicians deliver care.

Physician compensation was also a key discussion topic:

DAVID T. FEINBERG: We have studied physician RVUs, and we are currently separating our contracts into two levels. Level 1 is Clinician/Educator and Level 2 is Physician/Scientist. This approach to contracting and compensation seems to make sense in a large, complex academic medical center like UCLA.

MICHAEL J. DOWLING: The issue of appropriate physician compensation is like fighting World War III. But we have no other choice; we've got to do the right thing.

WILLIAM BROWN: Physicians are attracted to the opportunities our clinical integration models offer. We are focusing on a number of initiatives including clinical co-management, ACO participation, bundled payment models, and physician leadership development.

REYNOLD JENNINGS: We aren't sure if gain-sharing survives in the end, or if it's just a stop on the path to transformation. We've employed a lot of primary care physicians. There has been some recent pushback on their contributions towards corporate overhead, and we are working on that. One important focus for us is to reduce the variation in compensation plans. We are moving from 18 physician compensation formats to hopefully three. This standardization will be more equitable and easier to manage.

We have studied physician RVUs, and we are currently separating our contracts into two levels. Level 1 is Clinician/Educator and Level 2 is Physician/Scientist. This approach to contracting and compensation seems to make sense in a large, complex academic medical center like UCLA.”

DAVID T. FEINBERG
CEO & Associate Vice Chancellor, UCLA
Hospital System and Health Sciences

PRIORITIES

Leading Through Disruptive Innovation to Make Organizational Change Real

Healthcare Delivery and Payment Reform

The healthcare industry is undergoing a fundamental shift in how healthcare is delivered.

ELEMENTS OF CHANGE	TODAY	FUTURE
HEALTHCARE FOCUS	Sick care	Wellness and prevention
CARE MANAGEMENT	Manage utilization and cost within a care setting	Manage ongoing health (and optimize care episodes)
DELIVERY MODELS	Fragmented/silos	Care continuum and coordination (right care, right place, right time)
CARE SETTING	In office/hospital/person	Home health, e-health, m-health
PHYSICIAN PLATFORM	Solo practitioner	Multi-specialty, integrated
CLINICAL SYSTEMS / EMR	Transactional	Interoperable, health information exchanges
QUALITY MEASURES	Process-focused, individual	Outcomes-focused, population based
REIMBURSEMENT	Fee-for-service	Value-based (outcomes, utilization, total cost)
FINANCIAL INCENTIVES	Do more, make more	Perform better, make more
FINANCIAL PERFORMANCE	Margin per service, procedure, etc.	Margin per life

Source: Huron Healthcare

CURT B. WHELAN: CEOs are continuing to develop innovative business relationships with physicians, moving away from relationships that incent productivity exclusively, and toward an approach that incents physician citizenship and engagement, as well as clinical quality outcomes and the ability to deliver cost-effective care in a collaborative clinical model.

NEW BUSINESS MODELS: ACOs, POPULATION HEALTH MANAGEMENT, AND OTHER SHARED-SAVINGS AND RISK-SHARING ARRANGEMENTS

CEOs are exploring new business models—from formal, federally sponsored ACOs, to population health management models with their own employees, with employers, or with high-risk populations. Whether an organization forms an Accountable Care Organization or not, there was agreement that ACO-like competencies are necessary to thrive:

KEVIN SCHOEPLIN: Through our population management model, we are focused on redesigning how care is delivered to our patients. About 20 percent of our patient population is in at-risk payments and we see this percentage increasing. So we are quickly changing the way we approach accountability for our population.

KATE WALSH: I definitely think the play will be population management, taking on accountability for communities in your market.

Several CEOs expressed concern about hospitals' ability to effectively create population health and disease management capabilities on the timeline needed:

PATRICK A. CHARMEL: We know that incentives will soon begin to reward value-based and accountable care. We recognize that 80 percent of the ailments that we currently treat are acute exacerbations of chronic diseases, many of which are the result of an unhealthy lifestyle. I remember being at a conference not too long ago where provider accountability for population health was being discussed. There was outrage from hospital executives: "We have to take financial responsibility for maintaining or improving the health of a group of individuals—but they're non-compliant and irresponsible! They abuse their bodies! And we have to go at risk for them?" This is really going to be about engagement. Yes, people do live unhealthy lifestyles. The question is how we are going to develop effective interventions? A few organizations are aggressively trying to manage the health of the populations they serve because it's the right thing to do. In the not too distant future it is going to be imperative. It is extremely challenging work.

JOSEPH J. MULLANY: We are part of a Pioneer ACO. It's taken a significant amount of our management's time and energy. But we still don't have data from Medicare to see how it's working. Essentially we've spent an inordinate amount of time on a very small population.

Others shared their skepticism about the economic viability of risk-bearing and shared-savings models:

KEVIN SCHOEPLIN: One needs to think through the next steps if their path is only in shared savings models. At some point the savings will diminish and that's to be expected. The 'wars' don't begin until you have an off year and you have the parties need to prepare for the next economic reality.

STEVE CARLSON: With disease management, you get some short-term gain. But investing in wellness initiatives to better manage the health of a population, you're looking at a long-term gain that is yet to be defined.

PATRICK A. CHARMEL: As physicians assemble into Accountable Care Organizations and begin to respond to changing incentives, they may realize that the hospitals they've been aligned with are not the most desirable place to refer, because they are higher cost and lower quality than available alternatives. This will be a disruptive force.

Nearly all the CEOs were working on building population health management capabilities using their own employees. For many, that initiative is engaging employees on a deeper level and producing promising outcomes:

AL STUBBLEFIELD: Our organization is using our workforce as a learning lab for population health management. We've talked about it for 15 years, and we're doing it now. This is coming, so we want to have some experience.

WILLIAM K. ATKINSON: We are engaging our employees around lowering their cost of care and managing health. Around 70 percent of our workforce has been willing to do health screening in exchange for a lower insurance premium.

"We are engaging our employees around lowering their cost of care and managing health. Around 70 percent of our workforce has been willing to do health screening in exchange for a lower insurance premium."

WILLIAM K. ATKINSON
President & CEO,
WakeMed Health & Hospitals

MICHAEL VIVODA: We are using our employee base as a way to experiment with population health. Our employees can pay 20 percent less if they take certain preventive steps—like getting an annual physical or getting a flu shot. Forty percent of our workforce took advantage of this. We're also working on fine-tuning our health risk assessment to better identify chronic disease.

JEFF JONES: One of the things executives are looking at as they move toward population health management is how much control they need to have over the care patients receive outside of the hospital. These are things like home health, psychosocial support, nutrition, and community connectedness. The effectiveness of care across the continuum is crucial for reducing acute care incidents of chronic disease, as well as lowering readmissions. And there is significant variation in the network of services available on a market-by-market basis.

New relationships with payers flow out of new business models. CEOs described various relationships with insurers and employers—including ACO-like programs, disease management initiatives, and arrangements in which hospitals bear risk for quality outcomes.

However, CEOs were wary of putting all of their eggs in one basket. If a hospital had a risk-sharing agreement with one insurance company, they didn't necessarily want to duplicate that with another, given that reimbursement is still primarily based on fee-for-service models:

JAMES H. SKOGSBERGH: We have a special relationship with Blue Cross, where we're at risk for some health outcomes. It's working well. But the relationship is going to be challenged as things get tougher.

MICHAEL VIVODA: It is almost impossible to imagine that you wouldn't have different kinds of relationships with different kinds of payers. It's going to make for some very interesting dynamics.

There were several conversations about direct contracting with employers. CEOs expressed an increasing openness to new arrangements—even when those arrangements mean narrowing choice:

GARY S. KAPLAN: Employers are facing premium hikes every year. However, many of those rate increases are a result of the divergent costs of different providers. So if the health plan can isolate and segregate those providers whose high costs are driving up the rates rather than aggregating them and providing an aggregate rate, some downward pressure could be applied to premium costs. Our goal is to be the highest-value provider in the market. We want to put that message out to employers. Ideally, we would have employers coming to us to ask how they can take advantage of our lower prices. Today, many big companies want to lower costs, but don't want to restrict choice at all. That doesn't work. You need partners that understand that hospitals have to have margins.

AL STUBBLEFIELD: We made a presentation to the school board for lowering costs of care by sending all of their employees to our organization. We wrapped our proposal around an employee wellness program. In the past, they have not been willing to restrict choice. This time around, they were open like they have never been before.

ANDREW A. ZISKIND: The insurance models of narrow networks are growing, and it looks like they are here to stay. This kind of approach will open up different kinds of opportunities for payers and providers alike.

Other executives are aggressively exploring what it will take to become payers:

DAN WOLTERMAN: Capturing revenue and margin by going upstream toward insurance models is a critical and urgent strategy for our organization.

DAVID L. BERND: I'm glad we have a health plan—it gives us some balance in our portfolio. But it does make it hard to partner with insurance companies. They see us as a direct competitor.

JEFF JONES: New relationships between payers and providers hold a lot of promise for reducing costs and aligning incentives in innovative ways. But caution and ongoing communication and adjustments are crucial in making those relationships win-win. In particular, there are a lot of ways for gain-sharing agreements not to work. For instance, patient attribution is difficult. If the risk adjustment models are off, someone loses. And there also needs to be enough gain to be shared, which may not always be the case.

GORDON J. MOUNTFORD: CEOs are showing significantly increased receptivity to new kinds of relationships with payers as one strategy for getting access to data, sharing risk, and aligning incentives to increase the quality and affordability of care. The nature of the payer/provider relationships could be said to be revolutionary in this industry. The business models these relationships are establishing are still evolutionary.

LEVERAGING SIZE AND SCALE

Consolidate or collaborate? As one CEO put it, “You want to be too big to fail.” CEOs recognize that spreading fixed costs through consolidation or collaboration is one way to create efficiencies in

process and pricing. This approach can also help organizations quickly acquire new capabilities at a lower cost structure. In the long term, CEOs are considering how consolidation may help provide more effective population health management.

The opportunities—and limitations—of leveraging size and scale are very specific to local market conditions:

GARY S. KAPLAN: The marketplace is engaged in tremendous disruption. Each market is different. We want to understand what's going on in the markets and what we can do to thrive. We need to look at market forces and the disruptive innovations that we see.

KATE WALSH: We are all looking at a world that will be largely shaped by our state and the federal government in terms of how we get paid. We think that Medicaid payments will continue to decrease in the setting of national healthcare reform, even as Medicaid enrollment grows and Medicaid becomes the single-largest payer in our country by 2017.

For some organizations, this means they must seriously explore asset rationalization:

MICHAEL J. DOWLING: About 15 hospitals have closed in New York City over the past 10 years, and there will be more. At North Shore-LIJ, we have been at the forefront of consolidation efforts. It's what makes our system different from others in the region.

DAN WOLTERMAN: On any given day, there are empty, unused hospital beds in Houston. But despite the oversupply, entities continue to build new hospitals. To deal with this reality, we have been rethinking our distribution models for where we provide care and making decisions about rationalizing fixed costs.

Local Markets Influence Strategy

The opportunities—and limitations—of leveraging size and scale are very specific to local market conditions.

Market issues that must be taken into consideration when developing strategy include:

- Threat of competing market ACO initiatives
- Extent of physician alignment
 - Employed physician base
 - Presence of large physician groups
 - Strength of alignment (both employed and affiliated physicians)
- Degree of payer competition
- History of payer-provider collaboration
- Provider experience with financial risk arrangements
- Breadth and depth of provider organizational capabilities and infrastructure to manage increased financial risk
- Cultural acceptance of evidence-based medicine and standard care practices

Cost Reduction and Revenue Enhancement Can Yield 20-40% Benefit

To thrive in the new healthcare landscape, most providers will need to improve performance by 20 to 40 percent. Improvement of this magnitude necessitates a multi-pronged, multi-year, strategic approach in each of the four categories illustrated here.



Source: Huron Healthcare Performance Improvement Database

For others, it means calculating moves to stay ahead of competitors:

REYNOLD JENNINGS: Competitors are really stirring the pot. One health system is buying doctors throughout the state. Another is buying GI, pathology, and chemotherapy. So the play is afoot.

CURT B. WHELAN: It's increasingly clear that most strategies around leveraging size and scale are dependent on the landscape of local markets. Organizations must determine their strategy based on the intersection of the capabilities they already have and their market conditions. For instance, organizations that already have an insurance plan and a large physician group have very different approaches and opportunities compared to those who don't. Those variances drive different strategies.

JEFF JONES: In the short term, consolidation can be a way of getting more patients through an organization to maximize fee-for-service revenue. But in the longer term, consolidation can also be about capturing a larger population of patients—as well as the ability to capture information about those patients that enables proactive population health management.

NEXT GENERATION PERFORMANCE IMPROVEMENT

CEOs discussed the need for a more focused, granular, and disciplined approach to performance improvement throughout their organizations. They cited successful projects completed in key operational areas—from revenue cycle to supply chain improvements—that have netted millions:

REYNOLD JENNINGS: We have a Lean manager with experience from GM. He spent two days with our teams going through visual management concepts. When you're trying to tackle the hardest costs to get out, you have to have nimble

teams, you have to hardwire, and you have to get a laser focus on six or seven things to really concentrate on per quarter.

CHRIS D. CONSTANTINO: We have 11 hospitals that started at different levels with Lean. The board has really adopted the Lean philosophy, and we are expecting bigger savings yet to come. Lean changes the thought processes involved in making improvements in the hospital. It is a different philosophy for making change happen. And in that way, it is really a lifelong journey, a different way of enacting change.

STEVE CARLSON: It is shocking how enthusiastic our physicians became once they bought into Lean. I have never seen people drink the Kool-Aid like this—old and young alike embracing Lean. We've seen the greatest benefit in physician engagement in our clinics. We believe that we will be able to increase throughput by 25 percent.

JAMES G. GALLAS: The new healthcare reality demands a more disciplined, transparent, rigorous approach to performance improvement in all areas of operations. Organizations are taking a fresh look at improvement opportunities—and sustaining changes through improved accountability and metrics.

GORDON J. MOUNTFORD: Breakthrough cost improvements are a necessity for all healthcare institutions as they look for ways to make the capital investments they need to thrive in a changing landscape. Those breakthroughs will come from new ways of thinking about their operations, making fundamental changes to reduce costs, and executing those changes effectively and efficiently.

INFORMATION TECHNOLOGY AND ACCESS TO ADVANCED ANALYTICS

All CEOs at the Forum are making investments in technology and improving data collection and connectivity:

Leading Through Disruptive Innovation to Make Organizational Change Real

PRIORITIES: Key Takeaways

- CEOs are focused on bringing together the core competencies and people their organizations will need to succeed under value-based payment models.
- Transitioning from volume-based payment models while making significant improvements in care quality and patient-centeredness is a major challenge that will require cultural transformation, capital, and multiple years to achieve.
- Key components for change include forging new business relationships with physicians, exploring new business models, leveraging size and scale, approaching performance improvement with unprecedented discipline and rigor, and leveraging data from advanced analytics.
- To fund the investments needed to shift to value-based approaches, achieve quality improvements, and maintain margins at Medicare rates, many healthcare organizations will need to reduce costs in the range of 20 to 40 percent.
- Advanced analytics hold the promise of supporting value-based business models by providing unprecedented insights into the quality, effectiveness, and true costs of care.

DAN WOLTERMAN: We have one system for the ambulatory/doctor side and we just did an information exchange for our system. We connected faculty into it and now are in the process of connecting our HIS into it.

MICHAEL VIVODA: Our electronic health record has provided access to individual health records across the organization. Our expectation is that we will use the new analytics to eliminate unnecessary and ancillary testing.

However, IT initiatives remain an expensive and difficult undertaking:

MICHAEL VIVODA: I just read that a very well-known, large health system has had to invest \$300 million on top of their HIS investment to make it work.

JAMES H. SKOGSBERGH: As we bring physicians in, we're bringing their information systems in, too. Getting systems to talk is really hard. Bolt-ons, band-aids, you name it.

DAVID L. BERND: Go to a single vendor for your EMR or you will have tremendous operating problems going down the road.

NANCY HOWELL AGEE: We hired an army of people to implement our EHR across our organization, and then we let them go. Since they left, we really haven't optimized our EHR. So now, we're recreating the army. We're re-educating clinicians and standardizing EHR use. Going forward, it's not going to be a one-time thing—that army will be staying.

CEOs expressed frustration that healthcare IT is still not what it should be:

AL STUBBLEFIELD: I can go to Cairo and put my debit card in the ATM and it shows me how much money I have, but I can't go across town and access my health record.

LOWELL W. JOHNSON: We decided to slog through CPOE to get meaningful use dollars. In my experience, most people are creating a platform where CPOE could happen. It doesn't mean it will. This is still a siloed and fragmented industry.

There was broad agreement that the healthcare industry has only scratched the surface when it comes to achieving advanced functionality, creating data resources that reveal the true costs of care, and creating the predictive analytics needed to effectively manage population health.

DEAN M. HARRISON: Our electronic data warehouse is rich with data from a broad array of clinical and financial data systems. But right now, it's simply data. We need to find and then allocate resources to our performance analytics group to really look at the data strategically.

DAVID L. BERND: There was a flu epidemic a few years ago. Our infectious disease doctors put together a standard order set to use in the ER and in primary care settings. We were able to predict the peak and decline in our area before the Centers for Disease Control. That meant we had a better idea of what supplies we would need and when. And we were able to impact cost and quality.

Some conversations focused on the as-yet-unfulfilled promise of health information exchanges (HIEs):

AL STUBBLEFIELD: Money has been given to start health information exchanges, but there's no money being provided to sustain them. In Florida, the competitors refuse to trust each other. One HIE came together around military health care, and that was it.

Return on IT Investment is Not Yet Fully Realized

There are numerous hurdles to jump before IT investments can be fully maximized.

- Most IT efforts (and resources) have been committed to foundational EMR and CPOE capabilities, with little change in the cost and quality of care.
- Information exchanges, clinical decision support, and analytics (including predictive analytics) will be critical for future success.

Challenges include:

- Immature products
 - Vendors
 - Applications
- Lack of process design
- Lack of standardization of care
- Lack of evidence-based guidelines and decision support
- Lack of measurable measures

WILLIAM K. ATKINSON: I think the government really should come in and set up HIEs—like the phone system. Unless that happens, I'm not sure how we're going to make the progress we need.

PATRICK A. CHARMEL: I sit on the board of a developing HIE. My impression is that few hospitals are motivated to encourage the development of a statewide HIE, because in their mind an HIE undermines their earlier “electronic handcuffs” strategy of connecting community physicians to their hospital information system exclusively to ensure physician loyalty. Hospitals have invested heavily to gain a strategic advantage and see the HIE as taking away that advantage, which is inevitable.

JEFF JONES: Electronic health records are an important and necessary piece of a hospital's infrastructure. They automate the process of capturing and accessing information, and they allow organizations to share that information across a broader geography in real time. What they cannot do is fundamentally change the way care is delivered or provide insight into the best way to manage the cost of care. Those capabilities require a separate set of tools and skills, as well as a way of embedding that back into the organization in an actionable way. There is still a lot of work to be done to get there.

Priorities and Strategies at Three Top Healthcare Organizations: Sentara Healthcare, Advocate Health Care, and Carilion Clinic

Many organizations are beginning to redesign their positioning and fit in the market. In one session, three CEOs shared specifics of their unique approaches.

Nancy Howell Agee, President and CEO, Carilion Clinic

On developing physician leadership:

- We are very focused on developing deep and broad physician leadership.
- In our organization, we're not thinking of patients as inpatient or outpatient anymore. We have departments leading in a dyad model.
- A competitor came into our market to start an urgent care clinic. They let us know their plans and wanted to make sure that they could send their patients with no revenue source to our ED. One of our ED physicians spoke up and suggested that, rather than allow a competitor to come in and gain market share, we should open our own urgent care clinic. Because of the physician's leadership, our clinic was open well before our competitor's. It's an independent service line, we have a shared EMR, and we partner with primary care.

On new approaches to primary care and care coordination:

- We are in relentless pursuit of clinical integration. We want to be managing patient health, not reacting to it.
- We had the first NCQA Level 3 patient-centered medical home in Virginia. We also added 25 care coordinators across the system.
- It takes a village to care for patients effectively. One example from our organization is a woman I'll call Myrtle. She's 84 years old, a widow, and she lives alone. She's got multiple chronic conditions: congestive heart failure, diabetes, and depression. Myrtle bounces in and out of the hospital until one day, we set her up with a care coordinator I'll call Jill. Jill makes sure Myrtle has a primary care physician, gets her set up with in-home medical devices that report key metrics to care givers, and connects her with several community and social networks. Did Myrtle's disease get cured? No, but she was no longer hopping in and out of a hospital.

David L. Bernd, CEO, Sentara Healthcare

On redesigning care delivery and structures:

- A key strategy is primary care redesign. We have created patient-centered medical homes. As a result, we've increased capacity by about 30 percent, with fewer physicians. We've also increased primary care access and can offer same-day appointments.
- We're using a vendor who has a platform for online physician visits. We're looking at a lot of telehealth. We think that's going to be huge.

- Our chronic care program is getting good results, with a 27 percent decrease in readmissions and reduced ED visits.
- We're trying to do clinical integration in our market without capitation. We're looking at gain-sharing as an interim step.

On knowledge management and IT:

- We have installed Epic in eight hospitals and on over 400 physician desktops. We've built a data warehouse. And we have live tracking, daily, of clinical metrics. One of our most important efforts is to collect information from data in private practices, bring it into our data warehouse, and then produce reports for the physicians that detail patient care over the continuum.
- We're trying to get to pattern recognition and predictive medicine. We think this is incredibly important. We want to be able to push real-time information to doctors. For instance, we could actually push clinical pathways to physicians and alert them if their patient care is deviating from a pathway.

James H. Skogsbergh, President and CEO, Advocate Health Care

On breakthrough advancements in physician alignment:

- I think the secret sauce is alignment—and financial incentives toward alignment get physicians' attention.
- We go at risk for certain metrics—turnaround time in radiology, for instance. One physician saw money on the table there and said "hey, if radiology turnaround times don't improve, we'd like you to recruit new radiologists." Aligning incentives works.

On risk-bearing capabilities for population health and quality outcomes:

- We have a fixed-fee arrangement with Blue Cross, in which we work to provide better health outcomes at lower cost. So we pay a lot of attention to "trend to spend"—that is, how much of the fixed fee we have spent caring for the population defined under the arrangement and the size of our margins. But we still have an issue with getting data on our spending trend—in large part because of the time lag between data collection and data analysis. So it can be like flying blind. And when there are dollars at risk, it's a serious concern. We're having constant conversations both internally and with Blue Cross to make the kinds of adjustments that make the arrangement work.
- The risk-adjustment model is critically important. We didn't get it right out of the gate. We do think, however, that we're better off today in our relationship with Blue Cross than we would have been in a traditional arrangement with them.
- Case management is also critically important for taking on risk. We are focusing on the 2.7 percent of our patients that account for 30 percent of our healthcare spend. We're embedding case managers who work with patients. We're also working toward more accurate predictive modeling, trying to identify groups of patients where we can intercede early and make a real difference in utilization and outcomes.



Innovative approaches to stakeholder alignment are essential for thriving under value-based models. Well-positioned organizations will be those that are able to align economic and clinical efforts across the entire continuum of care, working toward common goals around the fundamentals—quality, efficiency, and cost reduction.

ANDREW A. ZISKIND: Innovations around economic and clinical alignment across the entire continuum of care—the hospital and physician, the inpatient and outpatient, the acute, post-acute—are underway, and they are essential for success.

Executives are approaching alignment in different ways. Several emphasized that getting recruiting and hiring right is the first step to ensuring optimal stakeholder alignment:

CHRIS D. CONSTANTINO: Alignment begins with the job interview. We have to be able to talk about what is valued in our culture, what is tolerated, what is not tolerated.

WILLIAM BROWN: We use Gallup employment screening services for all potential new hires. An effective screening process is critical to getting the right players into the organization.

Others discussed ways they've changed their organizational structure and incentives to support better alignment:

KEVIN SCHOEPLIN: Although we organize under separate regional geographies with an executive leading each, part of their annual incentive payout is based on how well the System as a whole performs, not just on local or regional performance. This aligns the Senior Leadership Team around the performance as a System, as well as the region.

LOWELL W. JOHNSON: I'm intrigued by the concept of "forced ranking" where, at the end of every project, each employee who was involved is placed in the top 10 percent, the middle 80 percent, and the bottom 10 percent. Everyone is counseled based on where they fall in those rankings.

CHRIS D. CONSTANTINO: I've eliminated key administrative positions on my senior team and replaced them with physicians. Getting physicians' input early on helps resolve issues and reduces the "blame culture" some physicians work in. Paying physicians' high salaries and not including them in the management process does not create the buy-in culture that is necessary for organizational success.

The dyad model, in which a physician and administrator are paired, was a frequently cited approach for balancing clinical and operational expertise:

MARK LANEY: We went to a dyad model and spent a lot of time getting physician leaders educated and trained—because great medicine skills don't necessarily translate to great leadership skills. It's not cheap; however it's less expensive for the organization in the long run than not doing it. Both members of our dyads have identical goals and incentive bonus opportunities—they sink or swim together. Each dyad is unique. It's kind of like a marriage. They have to decide how they're going to work together, and how they're going to gain consensus.

GARY S. KAPLAN: We have dyads throughout our organization. Lots of people think that the clinician does clinical and the administrative does financial—the reality is both are accountable for both.

Achieving True Alignment with Key Stakeholders

1) Physician Alignment

A hospital's ability to deliver highly effective care while managing care variation, lowering utilization, and delivering evidence-based medicine is, in large part, dependent on its ability to align physicians with the organization's goals.

To provide the clinical leadership hospitals need, physicians need to connect their day-to-day clinical decisions with the big picture imperatives of doing better with less. As one CEO put it, "You cannot move away from fee-for-service without physician alignment." Executives have had mixed experiences with physicians' interest and their ability to practice and lead in this way:

MICHAEL J. DOWLING: Every day I am emphasizing the bigger picture with physician groups. Some physicians in leadership positions have trouble getting the bigger picture about the system as a whole. It's so immense and so complicated we have to communicate about it. It can be very hard for them to be collaborative enough and tough enough with their peers to do what they need to do. However, they are ideal partners, because when they get it, changes are supported.

DAVID L. BERND: Physicians are not happy. If we're not careful, they could sub-optimize the whole system by focusing

on optimizing their own piece of it. After a talk on the rise of complex, chronically ill patients and their burden on the system, an orthopedic surgeon went to one of my people and said, "I don't care about diabetes. I replace hips." It's tough to bring those kinds of people around.

MICHAEL J. DOWLING: We are aggressively aligning with doctors. We have primary relationships with about 10,000 physicians and directly employ 2,500. It is a major piece of our business. Right now the major efforts are to bring in primary care physicians. Many of them are still operating in a fee-for-service model, so it is a challenge to achieve transformation to new value-based purchasing models. We plan to get to an owned medical group of around 3,500.

M. MICHELLE HOOD: We have an administrator who is an excellent internist. He told us working on these interdisciplinary teams highlighted for him the need for additional skills—skills he had not been taught in medical school or had to use in the traditional physician practice. He was used to working alone. I think that is common.

CATHERINE A. JACOBSON: To get physicians to collaborate across our academic medical center and community-based practices, we use service lines to get horizontal alignment. For instance, we'll bring physicians together to get agreement on heart failure protocols. You have to go project by project, getting everyone on board and working together.

Primary Care Physicians' New, Increasingly Vital Role in the Success of Value-Based Care Delivery

From patient-centered medical homes to coordinated care, the role of primary care physicians was described by CEOs as more vital to success than ever. As one CEO put it, "If we really wanted to solve the Medicare crisis and improve overall health, we'd double primary care physician salaries and slash specialists. Specialists will start to be a problem as systems start to rationalize."

Reynold Jennings: We see a whole lot of young people who do not want a primary care physician despite our best efforts to educate them about why it is in their best interest. Up to 70 percent of what primary care doctors see cures itself within 72 hours. But what discourages patients is they

call for an appointment, and they can't get in for 6 weeks. That can be dangerous.

Kevin Schoeplein: Through the work in our patient-centered medical homes, we are receiving great anecdotal reports. Currently we have over 50 adult Level III medical homes and several pediatric medical homes operating through a hybrid model.

Dan Wolterman: We have made a commitment that by 2015, all primary care will be in a home model.

David L. Bernd: We are working on driving clinical quality up through primary care. Patient access to primary care physicians is crucial. In addition to the clinical benefits, patient satisfaction goes way up when patients have easy access to their primary care physician. You have to re-engineer your system so doctors leave ten to 20 percent of slots open every day—and guarantee physicians that their incomes won't drop if they do that.

Having a compensation strategy that supports physician alignment is key. When you have to distribute the dollars is when the battle will begin. Physicians want economic protection as they change how to do business in the new environment.”

MICHAEL J. DOWLING
President & CEO, North Shore-LIJ
Health System, CEO Forum Chair

Executives also pointed out that physician employment did not automatically lead to improved alignment. Whether physicians are employed or independent, the culture shift toward value-based competencies continues to evolve:

MICHAEL J. DOWLING: Doctors want to be connected; the challenge is to get strategic alignment. That’s the culture shift that needs to happen over time—and it’s a tough one. Intellectually they get it, and yet, with many doctors, there is a resistance to being accountable.

CATHERINE A. JACOBSON: We keep telling the doctors that the sky is falling. When it doesn’t fall, they think, “Why should we change now?”

ANDREW A. ZISKIND: Hospitals and health systems are looking to strategically align all of their stakeholders. The endgame is a value-based delivery system that is prepared to manage population risk. We will continue to see changes in the way physicians are employed, compensated and managed.

From a financial perspective, finding the right models for physician compensation is very challenging. Providers in some markets are moving rapidly to employ all the physicians they can, while in other markets physicians remain largely independent:

DAVID T. FEINBERG: It probably goes without saying that new graduates are particularly attracted to an employment model. They actually have been trained to be better team players, and we think there is a higher level of productivity with them.

WILLIAM K. ATKINSON: Doctors want to make a good salary, but we are finding that is not as big a motivator as it once was, as long as they feel their salary is fair.

NANCY HOWELL AGEE: Our compensation plan for employed physicians is base salary, then two scorecards. The first scorecard is the same for all physicians and managers. Everyone in the group has to be at 80 percent before anyone gets a bonus. The second scorecard is on productivity.

Many CEOs with employed physicians have moved beyond using productivity as the sole or primary compensation driver, incorporating other metrics that reward increased levels of engagement:

WILLIAM K. ATKINSON: Our contracts have requirements around patient face-time and productivity. We have lost some physicians who didn’t agree with or couldn’t meet our guidelines. We told them we can’t pay you the same as a doctor who is seeing 25 percent more patients in the same amount of time as you.

DAVID L. BERND: We changed our compensation systems from 100 percent RVU to including specific clinical goals. It’s just the first year, so we don’t know outcomes yet. Aligning incentives is absolutely necessary.

CEOs also discussed strategies for motivating and engaging physicians:

M. MICHELLE HOOD: We are using a tool to measure physician engagement and what motivates them. Setting targets—but not micro-managing—and helping them get where they need to go is very important. We have also been looking very closely at how we can incorporate physicians’ “hierarchy of needs” into our approach.

CURT B. WHELAN: Creating optimal alignment between a hospital or health system and acquired physician practices is a major challenge. However, by taking a proactive approach—and being prepared to have crucial conversations before, during, and after an acquisition—hospitals, physician practices, health systems and acquired physicians alike can build collaborative, collegial relationships that benefit all stakeholders, especially patients.

2) Board Alignment

CEOs acknowledged the growing importance of board alignment as disruptive change continues to transform healthcare:

MARK LANEY: Board alignment is really important. Boards are risk averse, and they have tremendous fiduciary responsibilities. We can’t get too far ahead of our boards.

GARY S. KAPLAN: I believe one of the most underleveraged tools healthcare organizations have is their boards. We have a board skill map, and we recruit actively. We have one well-known governance expert on our board—he comes in for meetings from Chicago. We also have a rule that anyone who joins our board has to participate on a Virginia Mason team for two weeks in Japan to learn about Lean methodology.

NANCY HOWELL AGEE: I provide a briefing book to my board every month to try to educate them on the changes happening in the healthcare market in general and in our market.

CEOs also discussed the steps they’re taking to strengthen and streamline the structure of their boards:

KEVIN SCHOEPLEIN: We have three boards that meet together along with our System parent board. This invites and assures transparency, open dialogue, and fiduciary alignment across the corporate structures.

MARK LANEY: We merged our system and hospital boards into one board. We were having too many meetings.

Achieving True Alignment with Key Stakeholders

PEOPLE: Key Takeaways

- Alignment with stakeholders across the enterprise is essential for value-based payment models.
- Effective alignment begins with the recruiting process.
- To manage care variation, lower utilization, and deliver evidence-based medicine in a way that improves patient satisfaction, providers must align physicians with organizational goals.
- Board alignment is increasingly important. Strong board structures, education, and makeup are crucial to success.
- Collaboration and training are key to creating high quality, patient-centered, value-based care.

DAN WOLTERMAN: We eliminated advisory boards. We modernized and got rid of the other boards that weren't necessary. We are now down to one parent board and four subsidiary boards.

GORDON J. MOUNTFORD: CEOs are carefully considering the kinds of talent that will be needed to lead healthcare organizations into the future, and demonstrating a willingness to recruit board members from outside local markets to acquire that talent when necessary.

3) Next Generation Workforce

CEOs discussed what the healthcare workforce will need to look like in the future, and how to enable the new kinds of competencies healthcare workers need to deliver value-based care:

WILLIAM K. ATKINSON: The younger generation doesn't know about the mess we have. So they're the ones that are going to come and fix it. We recently gave \$3 million to a community college that is graduating a lot of our healthcare staff. If we're going to say we want to change healthcare, we have to incent our way to getting a new kind of workforce. If you're employing people with a two-year degree program, within eight years you can have a cultural revolution. We are trying to buy our way into changing the way providers provide care. We can help break the cycle.

Younger physicians tend to have different mindsets than older physicians—particularly around work-life balance and engagement with technology. CEOs discussed how to leverage these differences to support new models of care:

MICHAEL J. DOWLING: Another change is coming as more women become experienced physicians over the next 10 years. So, there definitely is a "gender effect" that we all will be dealing with. Some of that will be expressed in work models that provide better work-life balance than in the past.

DAVID T. FEINBERG: New doctors are all about work-life balance. They're also better team players, and they're more likely to deliver more coordinated care.

CATHERINE A. JACOBSON: New doctors are much, much more willing to work on teams.

NANCY HOWELL AGEE: The younger generation of doctors uses technology in big new ways. They don't think you have to talk with somebody to assess them.

WILLIAM BROWN: We offer many different options for physicians including private practice, employment, faculty positions, hospitalist positions, and medical directorships, just to name a few. Regarding technology, the first question we get from young physicians is about our capabilities around information technology—it's an incredibly important factor for young doctors.

Physicians on Boards

There was a discussion among CEOs about the value of having physicians serve on the boards of their own organizations. Several executives described their various approaches:

Mark Laney: I really think you need to have good physician representation on boards. You can't have a fully active partnership before giving them a seat at the big table. You do have to build physicians' skills for being a board member through work on committees and give them experience and training for it to work. But if you don't have a doctor at the table, true physician alignment is unlikely to happen.

Gary S. Kaplan: Our board member who is a governance expert doesn't think that physicians from your organization should be on your board. We certainly want them at the table—we invite our CMO and CNO to every board meeting.

Reynold Jennings: We weren't including our independent doctors from clinical service lines on our boards. So we have created a council that involves both employed and independent physicians who have privileges at our hospitals. They are identifying issues for us to address.

Elliot Joseph: We have four physician members on each of our local hospital boards. However, our 15-member parent board has one physician member who comes from outside our market and brings expertise in the art and science of improvement within an integrated delivery system.

New Approaches to Care Delivery and Patient Relationships

The transition from volume to value includes taking a more patient-centered approach to care delivery, with a broad focus on wellness. To support this, CEOs are building competencies to address health inside and outside the four walls of the hospital. They're also focusing on root causes of illness by addressing social, health, and psychosocial factors.

Whether an organization forms an Accountable Care Organization or not, they will still need to have ACO-like competencies: the ability to deliver greater healthcare value, lower costs, and higher quality care.”

ANDREW A. ZISKIND
Managing Director
Huron Healthcare

1) Clinical Quality and Efficiency

In addition to being the right thing to do for patients, improving clinical quality and efficiency is now becoming a financial imperative. Patients and payers are creating unprecedented pressure to achieve transformative change, improving outcomes and

the patient experience:

AL STUBBLEFIELD: Hospital by hospital, specialty by specialty—change is coming slowly. I read somewhere that it takes 17 years for a best practice to get adopted across this industry. We need to accelerate that process.

Several CEOs discussed their commitment to creating a high-reliability organization (HRO)—a concept used in other industries:

DAN WOLTERMAN: We have gone beyond driving patient safety—we want to be a high-reliability organization. We want to move our culture to be like the commercial aviation industry, where the only acceptable number of serious safety incidents is zero.

JOSEPH J. MULLANY: Right now, baggage delivery is more reliable than the healthcare industry. We are doing a lot of employee engagement around becoming a high-reliability organization and improving our patient satisfaction scores. We've also got a tremendous amount of work to do on readmissions. They're at least 30 percent too high. We're running pilot programs trying to get at that.

Others discussed specific tactics they are using to improve clinical quality and efficiency metrics—especially related to chronically ill, high-use patients:

MICHAEL VIVODA: We had a patient who'd had 15 ER visits and nine admissions within 18 months. We sent a nurse to see that patient at home. The first six months after the home visit, there was one ER visit and no admissions. We need to be able to take that and make it systematic. Whether we can afford to or not is another question, but it is the right thing to do.

DAVID L. BERND: Case managers are identifying patients with chronic illnesses, our “frequent flyers.” We follow up with them within 24 hours of their visit. We've been able to reduce readmissions by about 25 percent.

REYNOLD JENNINGS: Medication management is the issue that causes the most problems and readmissions. I was a pharmacist, and when I was ill for a while, even I had a hard time remembering if I had taken my meds. We're gathering data, identifying trends, and thinking about how to solve it.

WILLIAM K. ATKINSON: We have hired some concierge doctors on a contract basis to care for a lot of our high-need patients. That breaks the cycle of what would have been a \$10,000 visit to the emergency room for high blood pressure.

ANDREW A. ZISKIND: Improvements in clinical operations and quality are crucial to success in the new value-based reimbursement environment. Once an organization takes care of the basics—reducing length of stay, increasing care

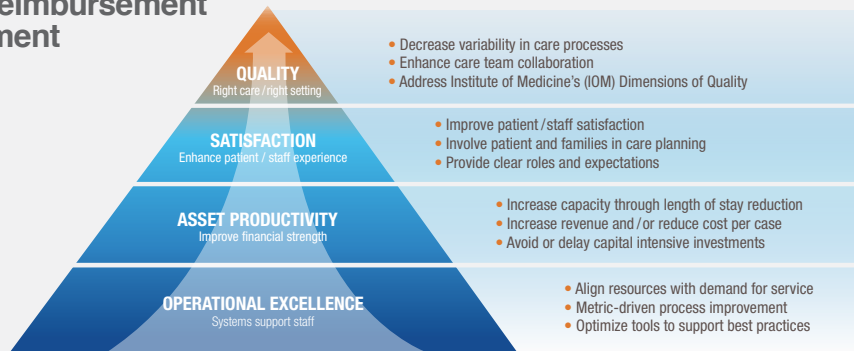
New Approaches to Care Delivery and Patient Relationships

PATIENTS:

Key Takeaways

- In addition to being the right thing to do for patients, improving clinical quality and efficiency is now a financial imperative for healthcare organizations.
- CEOs are building the structures and relationships needed to ensure that patients are receiving high quality care across the entire care continuum—both inside and outside the four walls of the hospital.
- Hospital leaders are increasingly focused on developing the capabilities needed to deliver effective wellness and preventive care.
- New care settings—especially home health and virtual care delivery—hold the promise of improving the patient experience while enhancing care quality and affordability.
- Significant changes in physician and operational structures are aimed at increasing healthcare providers' ability to engage patients and increase patient and family loyalty—particularly important in ACO models.

Clinical Quality & Efficiency Key to Thriving in Value-Based Reimbursement Environment



Source: Huron Healthcare

coordination, and improving care team communication—it can, and must, move on to advanced improvements such as standardizing care protocols and managing variation to drive breakthrough quality improvements.

2) Managing Care Across the Continuum

CEOs are working to foster a greater focus on wellness and preventive care to prepare for value-based reimbursement models, while decreasing costs. This effort requires new skills and a broad understanding of the efforts and initiatives that support wellness:

PATRICK A. CHARMEL: We are the only U.S. hospital with a Centers for Disease Control-funded Prevention Research Center, but public health officials and the state's health plans are slow to exploit our capability. Therefore, we are working proactively with volunteers—many of whom are healthcare professionals—affiliated with local churches and synagogues to provide health screening, education, coaching, and monitoring to members of their parish or congregation. We're also looking at using kids as agents of change within their families, working with schools to educate kids on making healthy choices.

LOWELL W. JOHNSON: We engaged with a Blue Cross plan to provide case managers to track patients not just through discharge, but after. Patients going that route were more satisfied with their care, so we are working on growing this approach. It's the right thing to do, and yet, from a volume-based model perspective, it reduces revenue since we will get less repeat business.

REYNOLD JENNINGS: In today's world with such a mobile population, there are fewer local social networks for people to rely on. Using social workers to research and address all aspects of a patient's lifestyle is a smart way to promote wellness.

CEOs are increasingly aware that mental illness is a key driver of costs and a root cause of poor quality outcomes. As state-provided behavioral health services are reduced, hospitals are finding ways to provide these services:

DEAN M. HARRISON: Behavioral health issues have become a major challenge for us. We operate one of the few remaining inpatient psychiatric facilities in the area. The state has drastically reduced services and closed facilities. We are seeing a significant increase in repeat visits in our emergency department from patients suffering from mental health issues.

NANCY HOWELL AGEE: Until Aetna shared their data with us, I had no idea how much substance abuse and mental illness were being treated by primary care physicians. We have a rescue mission in our area with 400 patient beds, and it's almost always full. Mental health has been a loss leader for us. Now we have to think about it differently. For starters, we're moving our psychiatric services into our community health services division.

REYNOLD JENNINGS: Providing mental health care can have a major impact in terms of time investment for a hospital. We did an analysis: Our staff was spending between 14-18 hours on around 20 patients a day who were coming into our ER with mental health issues. There is a significant time investment in getting these patients triaged, stabilized, evaluated, and then trying to figure out where they could go for the best care.

3) New Care Settings

CEOs are looking at new care settings inside and outside the hospital that will enable them to improve their patients' experience while providing high quality, efficient, affordable care. Home health was of particular interest, along with new technologies that enable virtual care delivery. In the past, it has often been prohibitively

expensive to deliver home health, but several CEOs shared developments that result in lower costs and more efficient care delivery:

M. MICHELLE HOOD: We need to be able to achieve clinical integration regardless of the site of care or where the patient presents.

KEVIN SCHOEPLEIN: When I think about what is out there that will be disruptive, I think about the whole application of technology, the use of telehealth. It is a game-changer.

WILLIAM K. ATKINSON: We have contracted with advance-practice paramedics who can treat and release patients in the field. If a patient has run out of a medicine, they can dispense off the back of a truck. This approach could save us millions of dollars.

GORDON J. MOUNTFORD: Access points for care delivery are quickly evolving to meet market pressures around cost, quality, and improved patient experience. Ambulatory settings, virtual visits, and home health are growing, and access to care is becoming customized and more convenient. New primary care models are a key component for success in the healthcare landscape. One key question is what role will traditional hospitals play in these models?

4) Patient Experience, Engagement, and Satisfaction

There has never been more at stake in the areas of patient experience and engagement. Reimbursement is becoming increasingly dependent on a hospital's ability to engage patients as active participants in their own plans of care, while improving patient satisfaction and loyalty:

KEVIN SCHOEPLEIN: We're on the road to building sustainable long-term relationships with patients and all those we serve. We are looking to interact with them beyond the venues of our hospitals and physician offices. We want to be able to impact their health and lifestyle decisions.

PATRICK A. CHARMEL: In the past, healthcare organizations wanted "compliant patients"—patients that don't ask questions or challenge their caregivers. We need to continue our shift toward viewing patients as partners in care. Holding meetings with families, discussing risks and benefits—what got you here in the first place, and what do we want to do? We presume we know what's best. But we often don't know the root cause of an acute care patient's encounter because we don't ask the right questions. There are likely underlying social, emotional, or economic issues. It could be that a husband or wife wants their spouse to remain dependent and therefore undermines

the spouse's efforts to improve health and well being. We often don't know. We just call them non-compliant. In the future, we will need to deal with the patient more holistically and enter into a true healing partnership.

Creating "listening posts" to gather patient feedback has become a focus:

DAVID L. BERND: We have really tried using the Internet and social media to get closer to our patients. We were monitoring Twitter, and one person in our waiting room was complaining about the wait. One of the people from our administration went down there and sought out the patient, and took care of the problem then and there. That really makes an impression on patients.

KEVIN SCHOEPLEIN: We use a hand-held device in the patient's room. We ask patients three to five questions about their experience.

Organizations are changing their physician and operational structures to improve patient experience and satisfaction:

DAN WOLTERMAN: We tried rolling out a centralized approach to patient experience with responsibility centered in one office. That approach didn't improve patient ratings, so we have gone back to a decentralized approach, and decided that patient experience is everyone's responsibility.

REYNOLD JENNINGS: We compared records and found 11 units that were dragging down our patient satisfaction scores. It turned out that those units were serving patients who were in the most pain. Nurses, doctors, and patients were all very frustrated with the conditions. So we have created physician team champions for each of these areas to provide a higher level of support for nurses and to provide more focused attention on pain management and patient engagement.

MARK LANEY: We have spent the last year and a half developing what we're calling the Heartland Experience. One of the initiatives we're piloting under this program is removing waiting rooms from clinics. After patients check in, they go directly to an exam room. It has been well received as something that the healthcare choosers really like.

ANDREW A. ZISKIND: Healthcare providers are thinking more and more about building and sustaining relationships with patients in new ways—including looking at what they can learn from customer relationship management (CRM) strategies used in other industries. Enhancing "patient stickiness" is especially vital for organizations participating in Medicare ACOs, where patients can choose any provider they'd like. If a patient's care and costs are attributable to you, and you've made an investment in preventive care for that patient, you want that patient highly satisfied and completely loyal.

Quality, cost-effectiveness, cost reduction initiatives, performance improvement goals, workforce optimization efforts: the list of initiatives under way in hospitals at any one time can overwhelm stakeholders.

1) Creating Organizational Focus

The key to engaging and leading stakeholders, CEOs agreed, involves setting clear priorities and making sure the organization stays focused on those priorities—often over multiple years:

DAVID T. FEINBERG: You can't do it all. You can't say "Our number one priority is..." and then list five things. We build our stakeholder messages around patient-centeredness. We fit everything we're doing under that umbrella. It gives us the ability to help the organization feel there is not too much going on, when clearly there is too much going on.

TERRY A. BELMONT: A strategic plan is absolutely essential for getting people involved and focused. When things are consolidating around us, we need to let our people know that we are following our strategic plan, that we will be okay and show them why.

AL STUBBLEFIELD: It's important not to let the urgent crowd out the important. You can spend all day and all night putting out fires if you let yourself be a firefighter.

CATHERINE A. JACOBSON: You don't want your staff worrying about healthcare industry trends and issues. You want them focusing their energy on patient care.

CURT B. WHELAN: Different organizations are pursuing different strategies to position themselves for the new healthcare landscape. Some are heavily pursuing payer/partner relationships. Others are pursuing a closed network strategy—developing everything in-house and capturing lives to manage population health. Others are pursuing a physician-based model to drive quality up and costs down. And then there are some hybrids in between. No matter which strategy an organization is using, the key steps are to make the strategy clear and cohesive with stakeholders and to create a laser focus on execution across the enterprise.

2) Capturing Stakeholder Attention

The fundamentals of communication haven't changed, but separating the signal from the noise is harder and harder for stakeholders whose attention is increasingly fragmented. Leaders must adjust the frequency, channels, and timing of communications to capture their attention:

JAMES H. SKOGSBERGH: We need to double communication efforts. At a recent physician leaders focus group, they blasted us: "You're not talking about all of the good things we're doing!" We feel like we never stop talking about it, and yet that wasn't the perception.

DEAN M. HARRISON: To keep your employee base focused on your top priorities, make sure they know your progress toward annual measurable goals. And communicate continuously. I have a blog. I've also found that, because I don't do a lot of written communications, when I do, everyone really listens.

CATHERINE A. JACOBSON: I've found that the communications people really pay attention to are those that come from their immediate supervisor.

REYNOLD JENNINGS: We do memos, town halls, and other typical communication efforts. I also make a point to go out and meet people. We have 12,000 people on staff, and so far I've met 7,000 of them. I have so many people tell me, "You're the first CEO of WellStar I've ever met." That blows me away.

KEY CHALLENGES & OPPORTUNITIES

PURPOSE

Leading and Engaging Stakeholders

PURPOSE: Key Takeaways

- With so many transformative initiatives underway, it's imperative for CEOs to set clear priorities and create organizational focus.
- Leaders must adjust the frequency, channels, and timing of communications to capture and keep stakeholders' attention and focus.
- Storytelling is a powerful tool for engaging and energizing stakeholders around goals and missions.
- CEOs continue to find that making personal, meaningful connections with stakeholders is one of the most effective leadership tools.

DEAN M. HARRISON: Each year we bring everyone together over the course of a few days to review our accomplishments, discuss goals for the next year, and answer questions. We're thinking about changing the frequency of our meetings. Rather than making a big production out of a once-a-year meeting, we are considering more frequent town hall meetings. To keep our employees focused on top priorities, we track and communicate monthly progress toward our annual goals.

One approach many executives are using to capture stakeholder attention is storytelling. Several executives cited a book called "Tell to Win," which describes how organizations can use the power of storytelling to engage stakeholders:

JOSEPH J. MULLANY: When we started our campaign around becoming a high-reliability organization, we took a pragmatic approach. It didn't resonate that well in our organization in terms of engagement. Then we shared a story of a preventable tragedy that had occurred at a hospital involving a child. And that really helped engage imaginations and energize people around the effort.

NANCY HOWELL AGEE: We do something called "Stories of the Heart." We collect stories from patients and families, and then we invite them to tell their stories at an annual event. After the story, we ask every single person who had any interaction with that patient to stand. It is very powerful.

3) Creating and Sustaining Organizational Change

CEOs must also demonstrate their leadership by creating accountability for continuous improvement. Creating and sustaining the new normal in healthcare means disrupting the status quo, insisting on a culture that continuously evolves and improves, and driving top-to-bottom accountability for excellence:

MARK LANEY: Culture may eat strategy for lunch, but if the culture isn't ready, change won't work. Culture is the most important thing a CEO can address.

REYNOLD JENNINGS: I believe the most crucial leadership skill is knowing what will really move the lever. You cannot get distracted by the random. You've got to see where there are systemic problems and go after those problems in a focused, disciplined manner.

WILLIAM K. ATKINSON: Innovation and change are the only way to grow. We have around 1,700 initiatives we are working on at any one time, and I have a small A-team assigned to each one of them. I tell them, "Don't stop until you bring me the head of the problem we are talking about."

GARY S. KAPLAN: I think one of the disruptive forces that has the potential to help us create organizational urgency for change is transparency in reporting around cost.

MARNA P. BORGSTROM: We are thinking carefully about how to bring cultures together throughout our system providers and how to align our organizational values to help ensure continued strong performance.

KATE WALSH: We need to make sure we're providing people with a sense of moving forward as a health system even as we continue to reduce costs in the hospital.

ELLIOT JOSEPH: We used to ask everyone to create their own organizational balanced score card. Now we have one balanced score card to look at across the whole system.

TERRY A. BELMONT: Positive, forward thinking, combined with strategic planning and accountability, are imperatives for moving priorities forward.

Insights from Business Leaders

HENRY SCHEIN, INC., U.S. TRUST, BANK OF AMERICA
PRIVATE WEALTH MANAGEMENT AND VIACOM INC.

Insights from Leaders at Henry Schein, Inc., U.S. Trust, Bank of America Private Wealth Management and Viacom Inc.

Captured here are highlights from top executives that became key topics of conversation throughout the event.

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KEITH BANKS
President, U.S. Trust,
Bank of America Private
Wealth Management

Keith Banks is president of U.S. Trust, Bank of America Private Wealth Management, which provides integrated investment, trust, banking and lending services to wealthy and ultra-wealthy clients. He also oversees Global Wealth & Investment Management Banking, which delivers a broad range of customized banking, credit and lending solutions to help meet the needs of high-net-worth and ultra-high-net-worth individuals, and BofA Global Capital Management, which offers money market funds, offshore funds, customized separate accounts and sub-advisory services to institutions and high-net-worth individuals. Mr. Banks is a board member of the Bank of America Charitable Foundation, and he sits on Bank of America's Chief Executive Officer's Operating Committee and Global Diversity & Inclusion Council. Mr. Banks previously served as president of Global Private Client, Institutional and Investment Management for Bank of America. This business included U.S. Trust, Institutional Retirement & Philanthropy, Alternative Investments Asset Management, and Columbia Management.



STANLEY M. BERGMAN
Chairman &
Chief Executive Officer,
Henry Schein, Inc.

Stanley M. Bergman is chairman and chief executive officer of Henry Schein, Inc., a Fortune 500® company and the world's largest provider of health care products and services to office-based dental, medical and animal health practitioners. With over 15,000 employees, and operations or affiliations in 26 countries, the company recorded 2011 net sales of \$8.5 billion. Henry Schein is a Fortune "Most Admired" company ranked #1 overall in its industry, and #1 for social responsibility, global competitiveness, quality of management, quality of products and services, and long-term investment. Mr. Bergman serves on numerous boards including the University of Pennsylvania, New York University, Columbia University Medical Center, the University of Witwatersrand, Tel Aviv University, Hebrew University, the Metropolitan Opera, Business Council for International Understanding, the American Dental Association (where he was awarded honorary membership) and The Forsyth Institute, the premiere oral health research institution in the United States.



PHILIPPE DAUMAN
President & Chief
Executive Officer,
Viacom Inc.

Philippe Dauman was named president and chief executive officer of Viacom Inc. in September 2006 and has served on the company's Board of Directors since 1987. Viacom is home to the world's premier entertainment brands that connect with audiences through compelling content across television, motion picture, online and mobile platforms in more than 160 countries and territories. With approximately 170 media networks reaching more than 600 million global subscribers, Viacom's leading brands include MTV, VH1, CMT, Logo, BET, CENTRIC, Nickelodeon, Nick Jr., TeenNick, Nicktoons, Nick at Nite, COMEDY CENTRAL, TV Land, Spike TV and Tr3s. Paramount Pictures, America's oldest film studio and creator of many of the most beloved motion pictures, continues today as a major global producer and distributor of filmed entertainment. Viacom operates a large portfolio of branded digital media experiences, including many of the world's most popular properties for entertainment, community and casual online gaming.

ON ENSURING ACCESS TO UNFILTERED INFORMATION:

KEITH BANKS: Create venues for direct access with clients and employees at all levels. I do that by traveling a lot and making sure that when I meet with a group of employees, the head of the practice or team is not invited. I don't want their presence to influence what our employees are saying.

PHILIPPE DAUMAN: As a leader, you cannot be isolated. That's a big danger. I have to travel—there are a lot of things going on outside the U.S. that are instructive about what might happen here. We also hire a lot of young people and make them a part of the enterprise. They know what's going on—they're using and consuming entertainment in a different way than I am. I have monthly sessions over breakfast or dinner with small groups of young people to hear their ideas, and understand where they're coming from. You can't get that just from reports.

STANLEY M. BERGMAN: Great leaders' greatest asset is rubber soles. Walk around and talk to team members, management, and customers. There's no replacement for that.

ON ENCOURAGING EMPLOYEE OWNERSHIP AND ENGAGEMENT:

PHILIPPE DAUMAN: An entrepreneurial attitude in a large company is critically important because work keeps moving faster and faster. We've really streamlined our organizational structure, eliminating layers so we can move quickly. The need to increase the velocity of business decision-making will only increase.

STANLEY M. BERGMAN: Running Henry Schein is kind of like running a private equity firm without the exit strategy: we want to build the business and create value. We encourage our managers to be entrepreneurial. We have three rules: comply with the law, treat your people well, and fit what you're doing with vision of the company.

KEITH BANKS: You have to engage your employees in order to transform them from spectators to players. Spectators watch and are critical of decisions. Players are on the field and empowered to make things happen. And once you're on the field, it's very hard to point fingers or disengage from the event. We need connected, engaged employees.

ON THE NEED TO OVERCOMMUNICATE TO EFFECTIVELY DELIVER KEY MESSAGES:

KEITH BANKS: As I was traveling and doing town halls with employees, I was shocked that they were not as well-versed in our mission, strategy, and vision as I would have thought, given the amount of communication we had done on those topics. It was clear that many people were hearing it for the first time. You have to overcommunicate your core values to your people.

PHILIPPE DAUMAN: We found out through a survey of our employees that they don't even know what healthcare benefits we provide. We've been forward thinking about a lot of stuff—they don't know we have it. They want to access information the way they consume information. So we've been pushing our providers to create apps about healthcare benefits to target our younger employees. There aren't any apps to do that right now. We need to overcommunicate with them.

ON GETTING CLOSER TO CUSTOMERS:

PHILIPPE DAUMAN: Our viewers, our customers, are the ones who are living through change. We spend a lot of resources on research. And it informs what we do, informs how we create new kinds of content and new experiences.

KEITH BANKS: To capture our clients' feedback more systematically and relationally, we created client advisory councils, which meet on a routine basis. When we speak with them, we ask open-ended questions, like, "If you were me, what would you be doing?" or "What do you think we could be doing differently?" Not only do we get valuable insights, but we actually see our clients transform into business partners. These clients now have a vested interest in our success because they feel like they own it. When they're engaged in that way, our clients become advocates and ambassadors for the company, which, in turn, helps us grow our client base.

ON SEEKING INPUT FROM HIGH PERFORMERS:

KEITH BANKS: As I travel, I always ask to meet with the high performers in each region. I'll ask them a few questions like what obstacles are preventing them from doing their job at an even higher level of performance or what should we be doing differently. I receive hundreds of great responses. If you ask people what's not working, they'll tell you how to fix it.

STANLEY M. BERGMAN: Seeking advice and engaging is the secret sauce to success. As a company, we are learning to be much better listeners. If you can engage people, they will help you get where you need to go. But if you can't engage them, even the most brilliant people cannot get you there. The biggest challenge is that when you ask for advice, you get answers. And if you don't follow up, when you ask again, you won't be taken seriously.

ON PREPARING TO THRIVE IN THE UNKNOWN:

PHILIPPE DAUMAN: It's imperative that we allow enough time to focus on the future while keeping our core teams running at high levels of performance. I also think a lot about positioning us strategically to take advantage of transitions in the business market when they happen. You don't have to be first. You can let your competitors try something and see how it goes. But you have to be ready to move when the time is right for you.

STANLEY M. BERGMAN: We stay on the leading edge of innovation in our field through joint ventures. It's a way to connect our core competencies to someone else's idea to minimize our risk and capital outlay. Managing joint ventures well is all about managing people and not being greedy about the share of profits. It's a lot of work, but joint ventures have continued to grow the company significantly. Right now, around 35 percent of our sales and related profits are in joint ventures. There's no way we would have captured these profits without a joint venture approach.

KEITH BANKS: Our key challenge for the future is ensuring that we are evolving with our clients and that we are driving changes that benefit them. Specifically, we are having extensive dialogue with our clients about their broad-based wealth management needs as opposed to solely focusing on investment results. We are helping prepare our clients' children for future financial inheritance and discussing elder care and estate planning, among many other important issues.

ON STRONG, EFFECTIVE LEADERSHIP:

STANLEY M. BERGMAN: Success is all about people—how you motivate, how you lead. People can be presented with a very bad set of circumstances, but if they're good leaders, they can do well. On the other hand, you can be presented with a great set of cards and botch it if you're a bad leader. It's more important to hire good leaders than technical leaders. Find the best person who can lead tax people. That's not necessarily a tax person. If leaders are sincere and walk the talk, they'll be fine. If they're just script-reading, they'll be seen through.

PHILIPPE DAUMAN: The most important thing to do is to allocate your time in the right ways. Have the right people working as part of your team and delegate to them so you have time to think. I have to be on top of the here and now—daily ratings and movie openings are my business. But at the same time, technology and consumers are forcing us to think about where the world is going to be in several years.

KEITH BANKS: Whether you're driving change or trying to change a culture, don't underestimate how much people want and need leadership. Get in front of your teams often, and let them know you have a plan and a vision for the future. Reinforce the commitment you and your leadership team share and the role every employee throughout the organization plays in the plan's success. As the plan unfolds, remind employees where you collectively started and how far you've progressed—and what the end goal is.

CONCLUSION

The challenge of a major business model shift in the healthcare industry continues to demand innovative strategies from CEOs and the organizations they lead. To thrive under the new business model, CEOs are looking for ways to make significant improvements in the quality and efficiency of care delivery.

Leading this change involves developing new competencies, exploring new partnerships and collaborations, and inspiring stakeholders to embrace new business arrangements and innovative ways of providing care. At the same time, leaders must also ensure that their organizations continue to perform well in the current business model, since the pace of change is uneven.

Increasingly, healthcare CEOs are called upon to be both visionaries and change agents—top CEOs are leading their organizations with new priorities, a laser-sharp focus, and engaging communications. The complexity of healthcare delivery puts a premium on alignment—physicians, payers, business partners, and board members all play key roles. CEOs must work with all stakeholders to foster a sense of shared purpose.

The goal through all of this is clear: keep more people healthy, deliver higher quality care, and significantly reduce costs. As CEOs and their leadership teams work together to meet these challenges, they are truly transforming the industry and inventing the future of healthcare.

EXECUTIVE ATTENDEES FULL BIOS



NANCY HOWELL AGEE
President & CEO,
Carilion Clinic

Nancy Howell Agee is president and chief executive officer of Carilion Clinic. Carilion is an integrated healthcare organization serving Western Virginia. Ms. Agee has served in various management roles with Carilion over the past 20 years. In 1996, she was appointed vice president and has gradually assumed increasing administrative and executive leadership roles. Ms. Agee holds degrees with honors from the University of Virginia and Emory University and participated in postgraduate studies at the Kellogg School of Business, Northwestern University. Additionally, she is a member of the Board of Commissioners, The Joint Commission – the preeminent organization that accredits hospitals and healthcare organization worldwide.



**WILLIAM K. ATKINSON, PHD,
MPH, MPA***
President & CEO,
WakeMed Health
& Hospitals

William (Bill) K. Atkinson, PhD, MPH, MPA is president and chief executive officer of WakeMed Health & Hospitals in Raleigh, North Carolina. Dr. Atkinson is a fellow of the American College of Healthcare Executives and holds adjunct faculty positions in the School of Global Public Health and the School of Medicine at the University of North Carolina at Chapel Hill. He is a member of the North Carolina State University's Kenan Fellows Board of Advisors. He is recognized nationally for his leadership in disaster preparedness and response, emergency medical services, workforce development, and for his work in reducing gang activity. He lectures frequently on innovation diffusion in healthcare, science, education, and public policy.



SCOTT BATULIS
President & CEO, Greater Hudson
Valley Health System,
President & CEO, Orange Regional
Medical Center,
President, Catskill Regional
Medical Center

Scott Batulis has been the president and chief executive officer for the Greater Hudson Valley Health System and Orange Regional Medical Center since August 2006 and president of Catskill Regional Medical Center since 2007. Mr. Batulis has more than 25 years of experience in healthcare administration including strategic planning, financial management, business development, mergers and acquisitions, hospital construction, operations management, physician relations, human resource development and fundraising. Throughout his leadership career, his broad-based healthcare system responsibilities have included hospital care, primary and specialty care, chronic care, senior care and home healthcare.



TERRY A. BELMONT
UC Irvine Medical Center, CEO,
Associate Vice Chancellor for Medical
Center Affairs

Terry A. Belmont became chief executive officer of the University of California, Irvine Medical Center and associate vice chancellor for medical center affairs in March 2009. Known throughout Southern California for his innovative approach to healthcare leadership, Belmont oversees one of the top tertiary care centers in Southern California and Orange County's only university hospital. He provides executive leadership to the medical center and UC Irvine Health, and creates close collaboration and partnership with the UC Irvine School of Medicine in the development of an integrated healthcare system, the transition into the new University Hospital and further expansion of UC Irvine's clinical programs.



DAVID L. BERND*
CEO,
Sentara Healthcare,
CEO Forum Co-Chair

David L. Bernd serves as chief executive officer of Sentara Healthcare, a \$4 billion integrated health system in Norfolk, Virginia. Sentara is comprised of 10 acute care hospitals, health plans with 440,000 covered lives, 618 provider medical groups and a medical staff of 3,680 physicians. *Modern Healthcare* magazine ranked Sentara the number one integrated health care network in the United States consecutively in 2010 and 2011. In 2012, Sentara earned the HIMSS Davies Award and HIMSS Stage 7 award and Mr. Bernd received the 2012 CEO IT Achievement Award. In 1985, Mr. Bernd was named executive vice-president/chief operating officer of Sentara Health System. In December 1994, he was named president and chief executive officer of Sentara Health System (now Sentara Healthcare).



MARNA P. BORGSTROM*
President & CEO,
Yale-New Haven Hospital,
Yale New Haven Health System

Marna P. Borgstrom is the chief executive officer of Yale-New Haven Hospital and president and chief executive officer of Yale New Haven Health System, based in New Haven, Connecticut. She joined Yale-New Haven Hospital nearly 32 years ago and has held her current position since 2005. Ms. Borgstrom is on the boards of the Connecticut Hospital Association, VHA, and the AAMC.



WILLIAM BROWN, FACHE
CEO,
Westlake Hospital

William A. Brown is chief executive officer of Westlake Hospital in Melrose Park, Illinois. Before joining Westlake, Bill's extensive healthcare experience included: system senior VP, Provena Health and president and chief executive officer of Provena Saint Joseph Hospital, Elgin, IL and Provena Mercy Medical Center, Aurora, IL; system vice president, Inova Health System, and chief executive officer of Inova Fair Oaks Hospital, Fairfax, VA; system executive vice president and chief operating officer, Alliant Health System, Louisville, KY; president and chief executive officer of Humana Hospital Audubon, Louisville, KY; system senior vice president of Jewish Hospital HealthCare Services; and president and chief executive officer of Frazier Rehab Center, Louisville, KY. Brown is a fellow in the American College of Healthcare Executives and serves as a preceptor for the School of Public Health, Masters of Healthcare Administration Program, University of Illinois at Chicago.



STEVE CARLSON
President & CEO,
Community Medical Center

Steve Carlson is the president and chief executive officer of Community Medical Center in Missoula, Montana. His experience includes nine years heading Flagstaff Medical Center in Flagstaff, Arizona. He was also a senior executive officer for Northern Arizona Healthcare.



PATRICK A. CHARMEL
President & CEO,
Griffin Health Services Corporation

Patrick A. Charmel, president and chief executive officer of Griffin Hospital and its parent organization, Griffin Health Services Corporation, has been associated with Griffin since 1979, when he served as a student intern while attending Quinnipiac University. After serving in a number of administrative positions, he became president in 1998. As president of Griffin Health Services Corporation, he is also the chief executive officer of Planetree Inc., a subsidiary corporation. Planetree is a not-for-profit organization that supports an alliance of over 170 hospitals located across the United States and in the Netherlands, Canada and Brazil and over 180 long term care facilities and ambulatory care centers that are committed to patient empowerment and the delivery of patient centered care.

EXECUTIVE ATTENDEES FULL BIOS



CHRIS D. CONSTANTINO
Executive Director,
Elmhurst Hospital Center

Chris D. Constantino is executive director of Elmhurst Hospital Center, a Level I trauma facility that serves nearly one million people in the most ethnically-diverse community in New York City. Prior to becoming executive director in 2005, he worked in a number of administrative and managerial capacities for Elmhurst Hospital Center, eventually rising through the ranks to become deputy executive director in 1991 and chief operating officer in 1994. Mr. Constantino has a Bachelor of Arts degree from the City University of New York and a Master's Degree in Public Administration from New York University. He is chairman of the board of the Interboro Regional Health Information Organization (RHIO), executive board member of Healthfirst and Shareing and Careing, a member of the American College of Healthcare Executives, and a fellow of the National Association of Public Hospitals (NAPH).



ANDREW DEVOE
CEO,
Physiotherapy Associates

Andrew DeVoe brings to Physiotherapy Associates more than 20 years of healthcare financial and operational experience in investor-owned and not-for-profit hospital providers across the country. Mr. DeVoe is an industry-recognized specialist who helps hospitals and healthcare organizations maximize key areas of their financial processes. In his initial role as chief financial officer, Mr. DeVoe's focus was centered on refining the processes of the revenue cycle of the firm and overseeing corporate financial matters. In June 2011, Mr. DeVoe was promoted to chief executive officer and has since been focused on recapitalizing the balance sheet (which was completed with the company sale to Court Square, in April 2012) as well as growing the business both organically and inorganically.



MICHAEL J. DOWLING*
President & CEO,
North Shore-LIJ Health System,
CEO Forum Chair

As the health system's president and chief executive officer, Michael J. Dowling oversees a healthcare network which delivers world-class clinical care throughout the New York metropolitan area, pioneering research at The Feinstein Institute for Medical Research and a visionary approach to medical education, highlighted by the Hofstra North Shore-LIJ School of Medicine. Prior to becoming president and chief executive officer in 2002, Mr. Dowling was the health system's executive vice president and chief operating officer. Before joining North Shore-LIJ in 1995, he was a senior vice president at Empire Blue Cross/Blue Shield. Mr. Dowling served in New York State government for 12 years, including seven years as state director of Health, Education and Human Services and deputy secretary to the governor. He was also commissioner of the New York State Department of Social Services.



CHRISTOPHER DRUMMOND
Managing Director,
Huron Healthcare

Christopher Drummond has more than 20 years of experience leading hospital-wide performance improvement efforts. Mr. Drummond has served as the chief implementation officer for hospital-wide performance improvement efforts, non-labor hospital engagements, and pharmacy and medication safety improvement engagements.



**DAVID T. FEINBERG,
MD, MBA***
CEO & Associate Vice Chancellor,
UCLA Hospital System and
Health Sciences

David T. Feinberg, MD, MBA is the president of UCLA Health System and chief executive officer of the Hospital System. Previously, he served as medical director of the Resnick Neuropsychiatric Hospital and head of the Neuropsychiatric Hospital Faculty Practice Group. Dr. Feinberg is also a clinical professor of Psychiatry on the faculty of the David Geffen School of Medicine at UCLA and associate vice chancellor of Health Sciences.



JAMES G. GALLAS
Managing Director,
Huron Healthcare

James G. Gallas brings over 26 years of healthcare operations and consulting experience, including prior leadership roles with other national consulting firms. He leads Huron Healthcare's Performance solutions service line, which encompasses the Revenue Cycle, Non-Labor and Workforce solutions. Mr. Gallas also serves as a client service executive for several of Huron Healthcare's provider clients



MUKESH GANGWAL
Managing Director,
Huron Healthcare

Mukesh Gangwal offers a wide range of strategic, operational and financial solutions to large hospital systems, university medical centers, physician practice plans and other healthcare organizations. He focuses on turnaround management and provides strategic and tactical advice to complex provider organizations. Mr. Gangwal is a member of the Huron Healthcare Leadership Team, responsible for Huron Healthcare strategy and other operational matters.



DEAN M. HARRISON*
President & CEO,
Northwestern Memorial HealthCare

Dean M. Harrison is president and chief executive officer of Chicago's Northwestern Memorial HealthCare, the parent corporation of Northwestern Memorial Hospital including its Prentice Women's Hospital and Stone Institute of Psychiatry, Northwestern Lake Forest Hospital, and Northwestern Memorial Foundation. Before joining Northwestern Memorial in July of 1998, he was President and Chief Operating Officer of the University of Chicago Health System.

Mr. Harrison currently serves on the Board of Directors and the Executive Committee of the Illinois Hospital Association, Member Board of Directors of the University HealthSystem Consortium, Board of Directors of the United Way of Metropolitan Chicago, Board of Directors of World Business Chicago, and Board of Directors of the Executive's Club and is a special advisor to Merrick Ventures. He is a former Chairman of the Metropolitan Chicago Healthcare Council Board of Directors. Mr. Harrison is a member of The Economic Club of Chicago, The Commercial Club of Chicago, The Institute of Medicine of Chicago and the Business Leadership Group for Workforce Chicago 2.0.



M. MICHELLE HOOD
President & CEO,
Eastern Maine Healthcare Systems

As EMHS president and chief executive officer, M. Michelle Hood, FACHE provides the leadership and vision that anticipates both advance and obstacles in healthcare. In addition to overseeing a system of health delivery services, she focuses on healthcare policy developments at the state and national levels, positioning EMHS to innovatively address the very specific needs and challenges of improving the health status of the people of Maine. Ms. Hood works at making connections and building creative partnerships that work for Maine communities, strengthening the economic and educational climate of the state, and ensuring that EMHS is a great place to work for more than 8,000 dedicated professionals. She is active with both the American Hospital Association and the Maine Hospital Association, and serves as chair of the University of Maine System Board of Trustees.

EXECUTIVE ATTENDEES FULL BIOS



L. LEE ISLEY, PhD, FACHE
CEO,
Granville Health System

Throughout his career, L. Lee Isley has specialized in working with rural health systems, focusing on building successful medical teams and providing quality care and exceptional services to the communities they serve. In August of 2006, Dr. Isley was selected as the new chief executive officer for Granville Health System. Working in conjunction with an effective board of trustees and an exceptional medical team, he has developed real estate joint ventures, program partnerships, service line ventures, practice acquisitions, quality initiatives and an ambulatory surgery center joint venture resulting in the System experiencing significant growth, doubling its medical staff and net revenues.



CATHERINE A. JACOBSON,
FHFMA, CPA
President & CEO,
Froedtert Health

Catherine A. Jacobson is president and chief executive officer of Froedtert Health in Milwaukee, Wisconsin. Froedtert Health is a regional health care system consisting of three hospitals, a community-based medical group and a variety of health care joint ventures. She joined Froedtert Health in 2010 as the executive vice president of finance and strategy, chief financial officer and chief strategy officer. She was appointed president of the health system in July 2011, and assumed the additional role of chief executive officer in July 2012. Prior to joining Froedtert Health, Ms. Jacobson spent 22 years at Rush University Medical Center in Chicago in a variety of roles, including chief financial officer of Rush's health plan, as well as chief compliance officer for the health system.



REYNOLD JENNINGS
President & CEO,
WellStar Health System

In August 2011, Reynold Jennings became the fourth president & chief executive officer of WellStar Health System. Previously, he served as chief operating officer of Tenet Healthcare Corporation where he had operational oversight of 69 core acute care hospitals and other facilities in 13 states. A native of Georgia, Mr. Jennings brought to WellStar 35 years of extensive experience as a hands-on hospital operating executive. Over his career, he held other executive leadership positions with Tenet Healthcare; Ramsey Health Care, New Orleans, LA; National Medical Enterprises and American Medical International of Florida. He also served as chairman of several healthcare associations and corporate entities.



LOWELL W. JOHNSON,
FACHE
CEO,
Salinas Valley Memorial
Healthcare System

Lowell W. Johnson has over 35 years experience as an interim chief executive officer, chief operating officer, chief financial officer and consultant in healthcare. He has served as interim president and chief executive officer of Salinas Valley Memorial Health System in Salinas, California since April 2011. Prior to this, he was interim chief operating officer at El Camino Hospital in Mountainview, California from June 2010 – April 2011. In 2010, he also served as interim president and chief executive officer of Evergreen Healthcare in Kirkland, Washington. From June 2009 – February 2010, he was the interim senior vice president and chief finance/turnaround officer for Saint Vincent Catholic Medical Center in New York, New York.



JEFF JONES
Managing Director,
Huron Healthcare

Jeff Jones has more than 24 years of experience helping large health systems, academic medical centers, children's hospitals and community providers to substantially improve their operational and financial performance. Mr. Jones is also a member of the Huron Healthcare leadership team, providing oversight for the day-to-day operations of the practice.



ELLIOT JOSEPH
President & CEO,
Hartford HealthCare

Elliot Joseph is president and chief executive officer of Hartford HealthCare (HHC), the premiere health care network in Connecticut with \$2 billion in net revenue and more than 15,000 employees in more than 80 communities. The HHC system includes acute-care hospitals, behavioral health and rehabilitation facilities and services, visiting nurse services, assisted-living and skilled-nursing facilities, and laboratory services. When he joined Hartford HealthCare in 2008 and until August 2011, Mr. Joseph also held the title of president and chief executive officer of Hartford Hospital. Prior to that role Mr. Joseph served as president and chief executive officer of St. John Health (SJH), a \$1.8-billion Southeast Michigan health care system.



**GARY S. KAPLAN, MD, FACP,
FACMPE, FACPE***
Chairman & CEO,
Virginia Mason Health System

Gary S. Kaplan is chairman and chief executive officer of Seattle-based Virginia Mason Health System. Under Dr. Kaplan's leadership, Virginia Mason was named a Distinguished Hospital for Clinical Excellence by HealthGrades in 2011, a Top Hospital by The Leapfrog Group for five consecutive years, and was one of two hospitals named a Leapfrog Top Hospital of the Decade for patient safety and quality. Dr. Kaplan is also a clinical professor at the University of Washington, board chair of IHI and on the National Patient Safety Foundation's board of directors. He serves on the board of Washington Healthcare Forum and is a founding member of Health CEOs for Health Reform. *Modern Physician* and *Modern Healthcare* ranked Dr. Kaplan 2nd on the 2012 listing of the 50 Most Influential Physician Executives.



WAYNE E. KEATHLEY
President and Chief Operating Officer,
The Mount Sinai Hospital

Wayne E. Keathley came to Mount Sinai in late 2003 as chief operating officer of The Mount Sinai Hospital and quickly assembled a talented and dedicated team for hospital operations. He recruited outstanding nursing and administrative leaders and created an operating culture that is dedicated to providing safe and compassionate care. He also helped build an external network of physician and hospital affiliates and energized business development efforts. This strengthened the institution's presence in local and regional communities and resulted in unprecedented growth and market share over the past five years. In 2008, Mr. Keathley was appointed Executive Vice President for Business Development of The Mount Sinai Medical Center. Later that year, he was named President of The Mount Sinai Hospital, and he continues to serve as Chief Operating Officer.



MARK LANEY, MD
President & CEO,
Heartland Health

Mark Laney has served as Heartland Health president and chief executive officer since 2009. Prior to Heartland, Dr. Laney served for 20 years at Cook Children's Health Care System in Fort Worth, Texas. For the first 13 years he was a pediatric neurologist, and from 2001 until 2009 he was the president of Cook Children's Physician Network, one of the largest pediatric multi-specialty groups in America.



BRUCE (SKIP) LEMON
Managing Director,
Huron Healthcare

Bruce (Skip) Lemon has more than 25 years of experience as a consultant in the healthcare industry. His clients include healthcare providers and software and health insurance companies. He has worked on a wide range of projects, including revenue cycle, operations improvement and information technology initiatives.

EXECUTIVE ATTENDEES FULL BIOS



GORDON J. MOUNTFORD
Executive Vice President,
Huron Healthcare

Gordon J. Mountford has overall practice responsibility for Huron's healthcare consulting business, Huron Healthcare. Mr. Mountford also serves on Huron's firm-wide leadership team. He brings more than 25 years of consulting experience, including 18 years focused on hospitals, academic medical centers, health systems, and payer organizations. His experience in the healthcare industry has focused on improving operational and financial performance in diverse environments.



JOSEPH J. MULLANY
President,
Detroit Medical Center

Joseph J. Mullany joined DMC as president in April 2012. He oversees DMC's operations and expansion of its ambulatory network. Mr. Mullany came to DMC from Vanguard Health System's New England region, where he served as president and chief executive officer since joining Vanguard in 2005. Mr. Mullany excelled at creating a culture of excellence within the New England region based upon a foundation of patient and family, safety, quality and value creation. While under his command for seven consecutive years, the hospitals within the New England region received numerous awards and honors, and developed several recognized service lines including excellence designation for stroke care, hospice, home care, and cancer care services.



RICHARD W. PETERSEN
President & CEO,
Maine Medical Center

Richard W. Petersen currently serves as president and chief executive officer of Maine Medical Center – the state's leading, nationally-recognized, tertiary and quaternary medical center with a 140-year history of healing and community stewardship. Before joining Maine Medical Center, Mr. Petersen served as senior vice president for Kaleida Health Systems located in Buffalo, New York. Mr. Petersen began his healthcare career in 1978 as an Assistant Administrator of a 101-bed community hospital located in Medina, New York, and, in 1984, was promoted to the position of chief executive officer. Between 1984 and 1996, he served as president and chief executive officer of a community hospital and later served as chief executive officer of a network of seven hospitals and one long-term care facility.



JAMES H. ROTH
Chief Executive Officer, President,
Huron Consulting Group

James H. Roth is the chief executive officer and president of Huron Consulting Group and one of the founding members of the Company. Prior to his appointment as CEO, Jim served as vice president of Health and Education Consulting. Mr. Roth also led the Higher Education consulting practice since the Company's inception in 2002, and under his leadership this business grew more than 10-fold. While serving as vice president of Health and Education Consulting, Mr. Roth expanded this business overseas into global markets to help address the rapid demands for improved health and education in emerging economies. Mr. Roth has more than 30 years of consulting experience working with many of the premier research universities and academic medical centers. *Consulting Magazine* named Jim one of the "Top 25 Most Influential Consultants" in 2009.



KEVIN SCHOEPLEIN
CEO,
OSF Healthcare System

Kevin Schoeplein is chief executive officer of OSF Healthcare System, president of OSF Saint Francis, Inc., president of OSF Healthcare Foundation and the vice-chairman for the OSF Healthcare System Board of Directors. Mr. Schoeplein began his career with The Sisters of the Third Order of St. Francis in 1978 as an assistant administrator at OSF Saint Francis Medical Center in Peoria, Illinois. Since 1983 when he was appointed administrator/chief executive officer at OSF Saint Anthony Medical Center in Rockford, Illinois. he has served in many key leadership roles including president of OSF HealthPlans, and just prior to becoming chief executive officer, as executive vice president of OSF.



JAMES H. SKOGSBERGH
President & CEO,
Advocate Health Care

James H. Skogsbergh is president and chief executive officer of Advocate Health Care (Oak Brook, Illinois), the largest health system in Illinois. Before joining Advocate as chief operating officer in January 2001, Mr. Skogsbergh served as executive vice president of the Iowa Health System in Des Moines, as well as the president and chief executive officer of Iowa Methodist, Iowa Lutheran and Blank Children's hospitals. Mr. Skogsbergh is a fellow with the American College of Healthcare Executives, the past chair of the Illinois Hospital Association's Board of Directors and recently concluded service on the board of the Metropolitan Chicago Healthcare Council. He also serves as chair of the American Hospital Association's Section for Health Care Systems Governing Council and a member of its regional policy board.



AL STUBBLEFIELD*
President, Baptist Leadership Group,
President Emeritus,
Baptist Health Care

After 27 years of service and leadership, June 1, 2012 marked Al Stubblefield's transition to president of Baptist Leadership Group (BLG), the patient experience consulting practice owned by the nationally renowned Baptist Health Care. He also retains the title of president emeritus of Baptist Health Care. In his new role, Mr. Stubblefield shares his experiences taking Baptist from single-digit patient satisfaction scores to winning the Malcolm Baldrige Award, and what it takes to create and sustain Leadership Courage and Workforce Trust, with partner hospitals and health systems across the country. He leads BLG's team of experts as they coach and teach partners how to develop a high performing, patient-centered culture where you reach your goals and sustain your outcomes, regardless of the challenges of our constantly evolving industry. Prior to this role, Mr. Stubblefield served as president and ceo of Baptist Health Care from 1999 - 2012, leading Northwest Florida's largest health system and pioneer of service and performance excellence in healthcare.



JOHN F. TISCORNIA
Managing Director,
Huron Healthcare

Throughout his career, John F. Tiscornia has been involved in the financial, business and regulatory challenges of the healthcare industry. His expertise covers governance issues and board development, management interface between CEOs and boards, turnaround assessments and implementing turnaround plans for healthcare providers. He also has experience in performance improvement, conversion to non-profit organizations, strategic planning for multi-hospital systems, consolidations, mergers and collaborations, as well as issues related to Catholic healthcare.

EXECUTIVE ATTENDEES FULL BIOS



MICHAEL VIVODA
President & CEO,
Cadence Health

Michael Vivoda is the president and chief executive officer of Cadence Health, serving the organization since 2004 and most recently as president of CDH. A veteran healthcare executive, Mr. Vivoda possesses significant expertise in operations, strategic planning, managed care insurance and multi-specialty physician group management. During his stewardship, CDH had many notable achievements including a refreshed commitment to service excellence, dramatic growth of the medical staff and Cadence Physician Group, extraordinary expansion of the laboratory business and execution of multiple strategic affiliations for CDH and Cadence Health.



KATE WALSH*
President & CEO,
Boston Medical Center

Kate Walsh became the president and chief executive officer of Boston Medical Center (BMC) on March 1, 2010. Prior to her appointment at BMC, Ms. Walsh served as executive vice president and chief operating officer of Brigham and Women's Hospital for five years. She served previously as the chief operating officer for Novartis Institutes for Biomedical Research.



CURT B. WHELAN
Managing Director,
Huron Healthcare

Curt B. Whelan leads the Integrated Solution and Sales and Marketing division for Huron Healthcare. He brings more than 20 years of experience managing comprehensive healthcare consulting and performance improvement engagements. Mr. Whelan's expertise includes integrating and translating market-based demand analysis, physician alignment, operations benchmarking, financial planning, and developing technology trends into actionable plans. His extensive knowledge of emerging healthcare delivery models, coupled with his functional approach to project management and planning, provides the required expertise to build consensus organizationally and with governance to implement strategic and cost repositioning plans.



DAN WOLTERMAN*
President & CEO,
Memorial Hermann Healthcare System

Dan Wolterman joined Memorial Hermann Healthcare System in 1999 and was named president and chief executive officer in 2002. Before joining Memorial Hermann, he was senior vice president of the Sisters of Charity of the Incarnate Word Health Care System. In addition to his role as president and chief executive officer of Memorial Hermann and serving on numerous local and national healthcare related board and committees, Mr. Wolterman is also an adjunct professor at The University of Texas School of Public Health and serves on the University of Houston – Clear Lake Healthcare Administration Program Advisory Council.



ANDREW A. ZISKIND, MD
Managing Director,
Huron Healthcare

Andrew A. Ziskind has over 25 years of experience spanning clinical care; academic health system leadership for both the physician and hospital/health system side; development of innovative primary and specialty care delivery systems; leadership in accountable care and payment reform; and national and international consulting. Dr. Ziskind leads Huron Healthcare's Clinical solution and provides leadership to the Academic Medical Center team.

* Denotes 2012 CEO Forum Cabinet Members
Titles reflect positions held at the time this report was published.

ACKNOWLEDGEMENTS

Special thanks to Huron Healthcare CEO Forum Chairman Michael J. Dowling, president and CEO of North Shore-LIJ, and his team for their partnership in inviting many of the guest speakers—several of whom serve on his board of directors—and for their work and deep commitment to making the event a valuable experience for attendees.

Forum co-chair, David L. Bernd, president and CEO of Sentara Healthcare, was also very instrumental in the development and execution of the program, as were each of this year's CEO Forum cabinet members. Their input and guidance on the Forum structure and content, and their leadership during breakout discussions, created a rich learning environment for all attendees.

Huron Consulting Group President and CEO James H. Roth, Huron Healthcare Executive Vice President Gordon J. Mountford, and Huron Healthcare Managing Directors Curt B. Whelan, Jeff Jones, Andrew A. Ziskind, James G. Gallas, Mukesh Gangwal, John F. Tiscornia and Bruce (Skip) Lemon also contributed to this report. We are also grateful for the contributions of Huron Healthcare Industry Advisor William Dwyer of Dwyer HC Strategist, LLC.

FOR MORE INFORMATION

To view the full content of this report online, or to download a PDF file of the report, please visit www.healthcareceoforum.com.

To discuss the contents of this report with a Huron Healthcare executive, access more of Huron's insights on healthcare, or learn more about how we can help address your organization's most pressing issues, please visit www.huronconsultinggroup.com/healthcare, call 1-866-229-8700, or e-mail us at huronhealthcare@huronconsultinggroup.com. You may also follow us [@Huron](https://twitter.com/Huron) on Twitter.

ABOUT HURON HEALTHCARE

Huron Healthcare is the premier provider of performance improvement solutions for hospitals and health systems. By partnering with clients, we deliver solutions that improve quality, increase revenue, reduce expenses, and increase physician, patient, and employee satisfaction across the healthcare enterprise.

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ABOUT HURON HEALTHCARE

Huron Healthcare partners with clients to provide comprehensive performance improvement solutions that improve quality, increase revenue, reduce expenses, and increase physician, patient, and employee satisfaction across the healthcare enterprise. Clients include national and regional integrated healthcare systems, leading academic medical centers, community hospitals and physician practices.

To see how Huron Healthcare solutions can empower your mission, contact us at 1-866-229-8700 or visit huronconsultinggroup.com/healthcare.

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